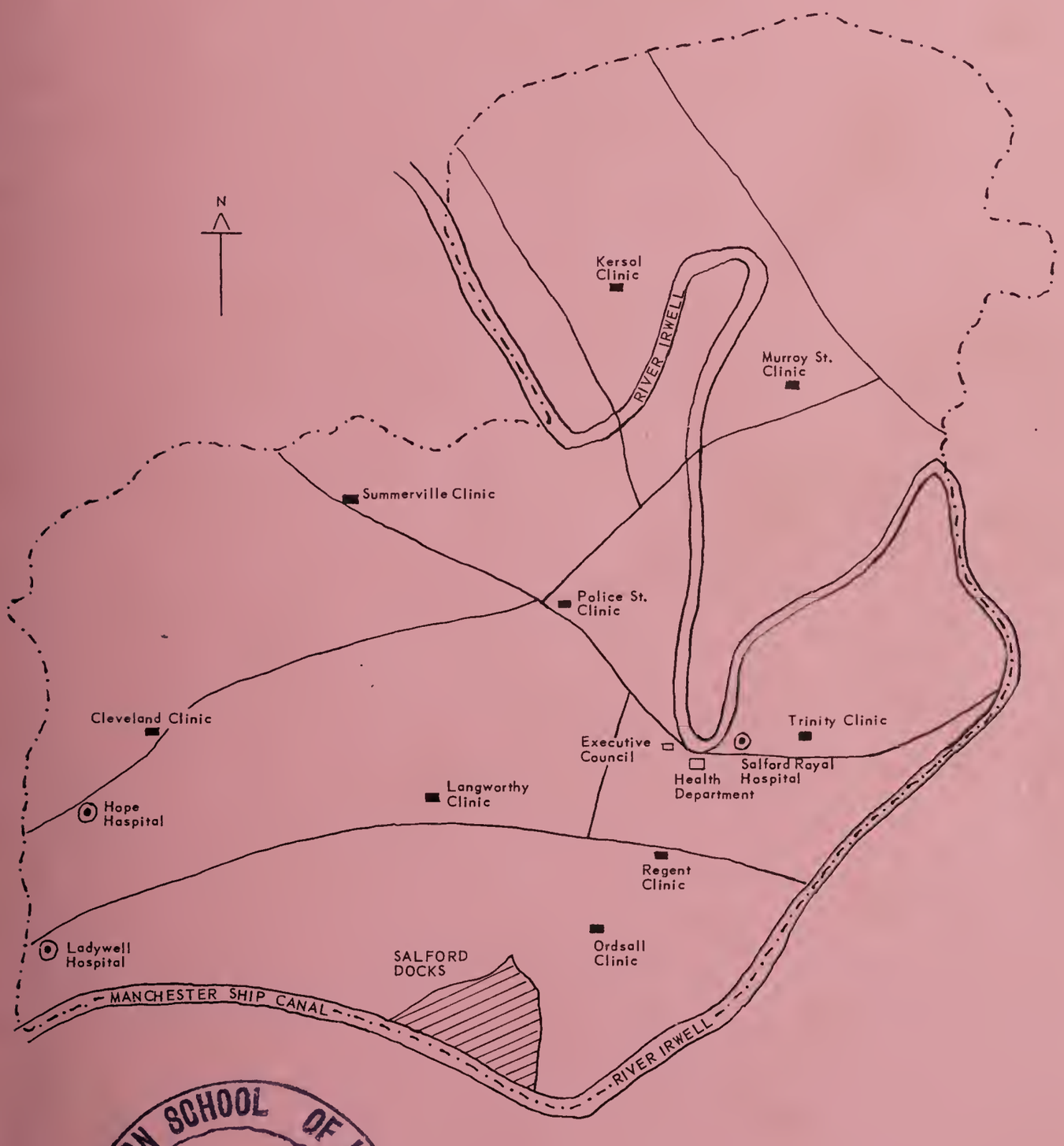
# CITY OF SALFORD

# ANNUAL REPORT OF THE MEDICAL OFFICER OF HEALTH 1965




# City of Salford

# ANNUAL REPORT

OF THE

# Medical Officer of Health

FOR THE YEAR

## 1965

BY

J. L. BURN, M.D., D.Hy., D.P.H.,

MEDICAL OFFICER OF HEALTH

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# MEMBERS OF THE HEALTH COMMITTEE

## at 31st December, 1965

---

His Worship the Mayor, Alderman Miss B. DAVIS, J.P.

*Chairman :*
Alderman MARGARET C. WHITEHEAD (Miss)

*Deputy Chairman:*
Councillor J. R. JAFFE

*Aldermen*

S. W. DAVIS, B.E.M.
E. E. MALLINSON, J.P. (Mrs.)
J. SHLOSBERG, J.P.

*Councillors*

A. ADAMS, (Mrs.)
A. ASHCROFT
H. COWIN, J.P. (Mrs.)
T. CUNNINGHAM
E. HOUGH
B. NOLAN
W. H. PARKER
J. G. WILLIAMS

# STAFF

## at 31st December, 1965

MEDICAL OFFICER OF HEALTH: J. L. BURN, M.D., D.Hy., D.P.H.

| | |
|---|---|
| DEPUTY MEDICAL OFFICER OF HEALTH | D. W. PRESTON, M.B., Ch.B., D.P.H. |
| CHILD HEALTH OFFICER | MARY S. GILBODY, M.B., B.Ch., B.A.O., D.P.H. |
| ASSISTANT MEDICAL OFFICERS | MARIAN MAXWELL REEKIE, M.B., Ch.B. |
| | ANNE E. MYERS, M.B., Ch.B. |
| | T. FRYERS, M.B., Ch.B., D.R.C.O.G., D.P.H. |
| PART-TIME SENIOR ASSISTANT MEDICAL OFFICER (MENTAL HEALTH) | (Vacant) |
| PART-TIME SENIOR ASSISTANT MEDICAL OFFICERS | D. H. VAUGHAN, M.B., Ch.B., D.P.H. |
| | H. A. JOHNSTON, M.B., B.Ch., B.A.O., D.P.H. |
| PART-TIME ASSISTANT MEDICAL OFFICERS | ELIZABETH HIGHAM, M.B., Ch.B. |
| | S.A. SILVER, M.B., Ch.B. |
| | A. BROWN, M.B., Ch.B., D.R.C.O.G. |
| | JENNIFER BROWN, M.B., Ch.B. |
| | K. PEARCE, M.B., Ch.B., D.C.H., D.M.S.A. |
| PART-TIME CONSULTANT STAFF | *R. I. MACKAY, M.B., Ch.B., M.R.C.P., D.C.H. |
| | *H. L. FREEMAN, M.A., M.B., B.Ch., D.P.M. |
| | *W. LEE, M.B., Ch.B. |
| PUBLIC ANALYST | G. S. MEADOWS, F.R.I.C. |
| CHIEF ADMINISTRATIVE OFFICER | H. MILLINGTON, B.A.(Admin.), A.I.S.W. |
| CHIEF PUBLIC HEALTH INSPECTOR | H. F. ROBINSON, F.R.S.H., F.A.P.H.I., C.S.I.B. |
| DEPUTY CHIEF PUBLIC HEALTH INSPECTOR | J. N. MARSHALL, M.R.S.H., M.A.P.H.I., C.S.I.B. |
| SENIOR ADMINISTRATIVE OFFICER | D. MARSHALL |
| CHIEF MENTAL WELFARE OFFICER | G. MOUNTNEY, Dip.Soc.Studies, A.A.P.S.W. |
| SUPERINTENDENT OF HEALTH VISITING AND NURSING STAFF | Miss D. LAMB, S.R.N., R.F.N., S.C.M., H.V.Cert. |
| DEPUTY SUPERINTENDENT OF HEALTH VISITING AND NURSING STAFF | Miss D. DUCKENFIELD, S.R.N., S.C.M., H.V.Cert. |
| SUPERVISOR OF MIDWIVES | Miss V. E. LANGRIDGE, S.R.N., R.F.N., S.C.M., M.T.D. |
| ASSISTANT SUPERVISOR OF MIDWIVES | Miss M. E. HODGSON S.R.N., S.C.M., R.M.N. |
| SUPERINTENDENT OF DISTRICT NURSES | Miss J. MARSDEN, S.R.N., S.C.M., Q.N., D.N.T. |
| ASSISTANT SUPERINTENDENT OF DISTRICT NURSES | Miss B. E. EGAN, S.R.N., Q.N. |
| DEPUTY CHIEF MENTAL WELFARE OFFICER | W. M. DOUGLAS, M.A., Dip.Soc.Admin., A.A.P.S.W. |
| PART-TIME PSYCHIATRIC SOCIAL WORKER | J. WRIGHT, Dip.Soc.Admin., A.A.P.S.W. |
| HOME HELP ORGANISER | Mrs. C. E. RIMMER |
| SUPERINTENDENT PHYSIOTHERAPIST | Miss P. K. FOGG, M.C.S.P. |
| CHIEF CHIROPODIST | B. D. BLANK, H.Ch.D., L.Ch., M.Ch.S., S.R.Ch. |

* By arrangement with the Manchester Regional Hospital Board

## STAFF *(continued)*

| | |
|---|---|
| ASSISTANT CHIEF PUBLIC HEALTH INSPECTORS | N. F. HARVEY, D.M.A., M.A.P.H.I., A.I.P.H.E., C.S.I.B.<br>H. L. LATHAM, M.A.P.H.I., C.S.I.B. |
| PUBLIC HEALTH INSPECTORS WITH SPECIAL RESPONSIBILITIES | D. C. JONES, M.A.P.H.I., C.S.I.B.<br>G. FOULDS, M.A.P.H.I., C.S.I.B.<br>J. CHURCH, M.A.P.H.I., C.S.I.B.<br>B. THORNLEY, M.A.P.H.I., C.S.I.B.<br>W. H. HASKAYNE, M.A.P.H.I., C.S.I.B.<br>K. WOOD, M.A.P.H.I., C.S.I.B., A.C.C.S.<br>R. TAYLOR, M.A.P.H.I., C.S.I.B. |
| SENIOR ADMINISTRATIVE ASSISTANT | Miss D. McMILLAN |
| ADMINISTRATIVE ASSISTANTS | L. F. HARPER, A.R.S.H.<br>D. WILLIAMS<br>F. ECKERSLEY |
| SENIOR CLERKS | T. O'ROURKE<br>H. WINSTANLEY<br>G. A. KELLY |
| AMBULANCE OFFICER | T. BLACKBURN, F.I.C.A.P. |
| MANAGER OF SALFORD HOUSE | D. HAZLETON |
| ASSISTANT SUPERINTENDENTS OF HEALTH VISITING AND NURSING STAFF | Miss K. ROEBUCK, S.R.N., S.C.M., R.F.N., H.V.Cert.<br>Mrs. D. APPLEBY, R.S.C.N., S.R.N., S.C.M., H.V.Cert. |
| CENTRE SUPERINTENDENTS (HEALTH VISITING) | Miss E. GREENHALGH, S.R.N., S.C.M., H.V.Cert.<br>Mrs. E. MILLINGTON, S.R.N., S.C.M., H.V.Cert. |
| HEALTH VISITORS WITH SPECIAL RESPONSIBILITIES | Miss E. GRIMSHAW, S.R.N., S.C.M., H.V.Cert.<br>Miss P. ANDERSON, S.R.N., S.C.M., B.T.A., H.V.Cert.<br>Miss A. B. HUTCHINSON, S.R.N., S.C.M., Dip.Trop.Nursing, H.V.Cert.<br>Mrs. E. F. JONES, S.R.N., S.C.M., N.N.E.B.Cert., H.V.Cert.<br>Mrs. M. KYTE, S.R.N., S.C.M., H.V.Cert.<br>Miss D. M. PARKER, S.R.N., R.F.N., S.C.M., H.V.Cert. |
| MIDWIVES WITH TEACHING RESPONSIBILITIES | Mrs. N. BENT, S.R.N., S.C.M.<br>Mrs. M. J. BROKENBROW, S.C.M.<br>Miss J. BUSH, S.R.N., S.C.M., M.T.D.<br>Mrs. S. NWOKO, S.R.N., S.C.M., M.T.D.(Part I).<br>Mrs. A. SMITH, S.R.N., S.C.M. |

# INTRODUCTION

MR. CHAIRMAN, LADIES AND GENTLEMEN,

In addition to trying to abate the nuisances and other environmental causes of poor health we are increasingly concerned with the positive factors in our surroundings and circumstances which lead to good health – clean air, safe and nutritious food, better housing, noise control and the provision of amenities as well as necessities for good living. We also seek to give better protective care of the young and the old by the prevention of disease and the alleviation, where possible, of physical, mental and social handicaps. We try to co-operate between the various services of the Corporation as well as with national and local agencies who help us in trying to provide the best care and after-care services.

We also try to alter some *behaviour patterns* which form increasing hazards to health. For example alcoholism can lead to liver disease and cigarette smoking to lung cancer and bronchitis; obesity may lead to greater hazards to health and comfort on account of cardio-vascular disease and arthritis. So we try to change harmful habits and attitudes to lessen these hazards and show the people a healthy and attractive way leading to increased enjoyment and effectiveness in living.

We have paid and are still paying special attention to women in those social groups where there are financial and other difficulties. We encourage them to take part in the cancer tests, both of the cervix and the breast – and in family planning. More and more we are deploying our services to deal with the people as and where they are. We have found that where the need is greatest for women to come forward, the response is poorest. So we have taken these services into the home.

A fine feature of our work is the skill of the *front-line team* who visit the homes of the people – the Health Visitor, District Nurse, Midwife, Home Help, Public Health Inspector, and Mental Welfare Officer. Real progress has been made in integrating their work with that of the family doctor.

## THE FAMILY DOCTOR HEALTH TEAM

Five teams have been set up with Health Visitor, District Nurse, Midwife, Psycho-Social Worker from our Mental Health Service. I can now say that most of our hopes have been realised and most of our fears have proved groundless. This teamwork is the keynote in the campaign for better health for to-day and for tomorrow.

The Salford Public Health Service had, for sometime, attached some Health Visitors, District Nurses, Midwives to those family doctors in group practice of three or more doctors who were willing to work more closely with our services. This has now been developed into a "family doctor" team of workers with the addition of what I term a psycho-social worker – one of our mental welfare officers who has a degree or diploma in social work. In co-operation with the family doctor he will try to help in the problems of patients suffering from neurosis, maladjustment and mental disorder. He will also be able to give social help and support as a trained social case-worker when called upon.

Three conditions are observed – firstly, in addition to daily visits, a "case conference" type of meeting should be held weekly, even if only for a short time to discuss problem patients and patients with problems. Secondly, to give the Health Visitor access to records in order that we may improve the service given, e.g. to visit the elderly patients systematically, even if they have not visited the doctor in order that their health may be promoted and disorder prevented as far as possible. Thirdly, to give special care to the 'high risk' group of patients, whether they be the blood relatives of diabetics, or the chronic bronchitics, epileptics, the overweight and the disabled, in order that appropriate members of the team can give the best help possible under the circumstances.

Family doctors have been impressed with the knowledge of the family and social circumstances which have affected their patients' health. New light is thrown on some of the patients' problems and sometimes has led to a re-casting of the tentative diagnosis and treatment given.

The great feature of this service is that the family doctor meets Local Authority staff as professional colleagues – not as technicians to do "this or that". The whole status of the public health nursing service is raised. For instance, infant feeding can in most cases be left entirely to the Health Visitor. In this way the mother will get clear-cut, consistent advice, based on wider experience than can fall to the lot of the average G.P.

There is a two-way exchange of information which leads to a greater understanding of the patient's need, and therefore to a better service to the family. There is discussion of the social background and present circumstances of the patient and his family. This is often illuminating to more than one member of the team. A better understanding of, and regard for, each other's work grows up.

I am sure that this is the best way for all members of the team, including the family doctor, to learn more about the practice of social and preventive medicine; not so much by lectures but as it is in reality; not through theory but in the handling of practical problems.

Attachment of the public health staff in the past has been on a basis separate to each worker. In my area, they are now working as teams in five group practices. We plan more. As in the past, the attachment of the team of public health staff is not whole-time, but their duties with the family doctors are the first and major call on their time. This has meant a saving of time of the doctors. An analysis of the minutes spent in every separate task of the district nurse when she worked more or less independently of the doctor compared with her work as a member of the team, showed a great saving of her time as well.

In these days of family doctor crisis, shortage of highly-trained staff, and increasing load on the health services, this is of great significance.

The front line team will have a link with other health workers; for example, with the home help, with the night sitter-in service, to help relatives who are caring for disturbed patients and also in the case of terminal illness. The family may be willing to care for their sick relative during the day, but they cannot be expected to give care during the night. The sitter-in can perform simple domestic tasks.

In these days when psychological stress seems so important, and where tranquillisers and anti-depressant drug treatment is on such a big scale, we shall try to see how best to support patients by encouraging them into a healthy way of life.

A feature of this work is that it has involved no capital expenditure of building of Health Centres, though all members of the five teams now working look forward to the day when they will practise from convenient premises, but we need not wait for this day.

There are also still far too many women in the country who do not take full advantage of the excellent opportunities for preventing disease and disability in the ante-natal period. Reading the Chief Medical Officer's enquiries into maternal deaths, one is grimly reminded of the neglect of some women to have proper attention in the pre-natal period.

This came to light locally when Dr. D. H. Vaughan and Mrs. Fawcett, Community Nurse, were chiefly responsible for an enquiry into the higher perinatal and infant mortality in this area compared with the national rate.

Dr. Vaughan reports as follows –

## STILLBIRTHS AND INFANT DEATHS – 1965

Salford in common with the North West of England has always had stillbirths and infant mortality rate higher than those of England and Wales as a whole. The lowest infant mortality rate ever recorded in the City was 24 in 1959. For four successive years after this however, the rate rose until in 1963 it was 31. Although it has now fallen again to 27, this compares unfavourably with the rate for England and Wales which continued to fall steadily until it reached 19 in 1965. The situation seemed to require close study along lines suggested by recent large scale national investigations, with a view to determining if possible the reason for the recently rising rate and why the local rate was so much above the average for the country.

It was decided to study intensively all the stillbirths and infant deaths which occurred during 1965. A health visitor was employed to search out all the available records, to interview the mothers to find out as much as possible about the families concerned, and if necessary to discuss the cases with the staff who had been involved. All concerned have been most co-operative and a great deal of information has been obtained – so much in fact that it has not yet been possible to analyse it fully. The results already confirm that certain groups of mothers have a higher risk than others of losing their babies – particularly those over the age of 30, those who already have 3 or more children and those in Social Classes IV and V. Particularly high rates are experienced by those mothers who have previously lost a baby, and by mothers who were thought to have a poor diet during pregnancy. As far as the cause of death is concerned the two most important groups are those babies who are born prematurely and those who die at the age of about three months from what is thought to be a rapidly fatal infection. For comparative purposes it has been necessary to collect information about mothers who have not lost their babies and this has provided interesting data concerning some aspects of ante-natal care.

The study has shown some factors to which more attention might be paid :–

1. Particular care should be taken to see that all expectant mothers receive continuous care from an early stage of pregnancy. For example, some mothers have their pregnancies confirmed and then do not attend again for several months, others do not readily understand or accept the advice they are offered ;

2. Especially close supervision is necessary for all mothers who have previously lost a baby or had a premature labour ; for those who attend for care for the first time after the fifth month of any pregnancy ; and for those who have a special problem in the family – for example low or uncertain income or chronic illness ;

3. Perhaps the greatest deficiency encountered during the survey was that very few of the families which had lost a baby had had adequate information regarding the cause of death or advice regarding future pregnancies. These families welcomed the opportunity to discuss their problems and worries with the health visitor carrying out the enquiry. It must be added that Dr. R. I. Mackay, Paediatrician at Hope Hospital, makes it clear to the parents of the children he has seen that he is always willing to discuss problems with them. Few however, take advantage of this.

---

1965 saw the retirement of Miss Beatrice M. Langton, M.B.E., D.N., Superintendent Health Visitor. She had rendered exceptional service to the Corporation over a period of 25 years in Salford. Her faithful and distinguished service will long be remembered in Salford and elsewhere.

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I would like to pay the warmest tribute to the members of the professional, administrative and manual staff of the Salford Public Health Service for all the good work they have done during the year. Our people need, and deserve, the best that we can give.

To the Chairman and members of the Health Committee who have supported the staff in their work, I would like to express my sincere gratitude. Their work is described in these pages.

To my colleagues, the family doctors and to my fellow chief officers who have rendered help to the Press and to the public, I would like to offer my grateful thanks.

I have the honour to be, Mr Chairman, Ladies and Gentlemen,

Your obedient Servant,

J. L. Burn

*Medical Officer of Health.*

HEALTH DEPARTMENT,
CRESCENT,
SALFORD, 5, LANCS.

Telephone : PENdleton 5891.

# STATISTICAL SUMMARY – 1965

(Based upon figures supplied by Registrar-General)

| | | | | |
|---|---|---|---|---|
| Area – The City of Salford has a total area of 5,203 acres | | | | |
| Population – (Registrar-General's Estimate at Mid-year 1964 | | | | 148,260 |
| ,, – (Census, 1961) | | | | 155,090 |
| Density – The Mean Density of the City is equal to 28·50 persons per acre | | | | |
| Live Births – Legitimate: | 1,380 Males | 1,321 Females | | 2,701 |
| ,, ,, – Illegitimate: | 187 Males | 166 Females | | 353 |
| | | | Total | 3,054 |
| Live birth rate per 1,000 population | | | | 20·60 |
| Still-births: 34 Males | 34 Females | | | 68 |
| Still-birth rate per 1,000 live and still-births | | | | 21·78 |
| Total live and still-births | | | | 3,122 |
| Infant Deaths (deaths under 1 year) Legitimate 71, Illegitimate 9 | | | | 80 |
| Infant mortality rate per 1,000 live births – Total | | | | 26·20 |
| ,, ,, ,, ,, ,, ,, ,, – Legitimate | | | | 26·29 |
| ,, ,, ,, ,, ,, ,, ,, – Illegitimate | | | | 25·49 |
| Neo-Natal mortality rate (deaths under 4 weeks per 1,000 total live births) | | | | 17·35 |
| Early Neo-Natal mortality rate (deaths under 1 week per 1,000 total live births) | | | | 15·06 |
| Illegitimate live births per cent of total live births | | | | 11·56 |
| Perinatal mortality rate (still-births plus deaths under one week per 1,000 total births) | | | | |
| Still-births 68 / Deaths under one week 46 | | | Total, 114 | 36·52 |
| Maternal deaths (including abortion) | | | | 1 |
| Maternal mortality rate per 1,000 live and still-births | | | | 0·32 |
| Deaths: 948 Males; 975 Females; | | | | 1,923 |
| Annual rate of mortality per 1,000 of the population | | | | 12·97 |

## TABLE I

SHOWING THE BIRTHS IN THE CITY OF SALFORD, DEATHS OF LEGITIMATE AND ILLEGITIMATE INFANTS UNDER ONE YEAR OLD AND THE PROPORTION OF DEATHS UNDER ONE YEAR OF AGE PER 1,000 BIRTHS DURING THE YEARS 1944 TO 1965.

| Years. | Births. | | | Percentage of Illegitimate Births to Total Births | Deaths under One Year. | | | Proportion of Deaths under One Year per 1,000 Births. | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Total. | Legit. | Illegit. | | Total. | Legit. | Illegit. | Total. | Legit. | Illegit. |
| 1944 | 3251 | 3025 | 226 | 7·0 | 202 | 182 | 20 | 62 | 63 | 88 |
| 1945 | 3022 | 2749 | 273 | 9·0 | 183 | 168 | 15 | 61 | 61 | 55 |
| 1946 | 3849 | 3610 | 239 | 6·2 | 205 | 180 | 25 | 53 | 50 | 104 |
| 1947 | 4220 | 3973 | 247 | 5·9 | 258 | 240 | 18 | 61 | 60 | 73 |
| 1948 | 3761 | 3570 | 191 | 5·1 | 157 | 147 | 10 | 42 | 41 | 52 |
| 1949 | 3628 | 3387 | 241 | 6·6 | 193 | 181 | 12 | 53 | 53 | 50 |
| 1950 | 3354 | 3123 | 231 | 6·9 | 144 | 128 | 16 | 43 | 41 | 69 |
| 1951 | 3091 | 2881 | 210 | 6·8 | 107 | 103 | 4 | 35 | 36 | 19 |
| 1952 | 3100 | 2913 | 187 | 6·0 | 107 | 89 | 18 | 35 | 31 | 96 |
| 1953 | 2964 | 2794 | 170 | 5·7 | 95 | 83 | 12 | 32 | 30 | 71 |
| 1954 | 2867 | 2692 | 175 | 6·1 | 87 | 79 | 8 | 30 | 30 | 46 |
| 1955 | 2700 | 2544 | 156 | 5·8 | 81 | 75 | 6 | 30 | 29 | 32 |
| 1956 | 2826 | 2682 | 144 | 5·1 | 83 | 80 | 3 | 29 | 30 | 21 |
| 1957 | 3026 | 2851 | 175 | 5·8 | 88 | 84 | 4 | 29 | 29 | 23 |
| 1958 | 2930 | 2738 | 192 | 6·5 | 84 | 78 | 6 | 29 | 28 | 31 |
| 1959 | 2959 | 2789 | 170 | 5·7 | 71 | 67 | 4 | 24 | 24 | 24 |
| 1960 | 2991 | 2752 | 239 | 8·0 | 80 | 73 | 7 | 27 | 27 | 29 |
| 1961 | 3018 | 2769 | 249 | 8·3 | 85 | 79 | 6 | 28 | 29 | 24 |
| 1962 | 3199 | 2911 | 288 | 9·0 | 93 | 85 | 8 | 29 | 29 | 28 |
| 1963 | 3154 | 2832 | 322 | 10·21 | 98 | 95 | 3 | 31 | 34 | 9 |
| 1964 | 3053 | 2703 | 350 | 11·46 | 93 | 78 | 15 | 30 | 29 | 43 |
| 1965 | 3054 | 2701 | 353 | 11·56 | 80 | 71 | 9 | 26 | 26 | 25 |

## TABLE 2

SHOWING THE BIRTH RATES, RATES OF MORTALITY FROM ALL CAUSES, TUBERCULOSIS OF RESPIRATORY SYSTEM, CANCER, HEART DISEASES, BRONCHITIS AND PNEUMONIA AND THE INFANT MORTALITY RATES DURING THE YEARS 1948 TO 1965.

| Years | Population estimated to middle of each year | Rates per 1,000 Population | | | | | | | Deaths under one year of age per 1,000 Births. |
|---|---|---|---|---|---|---|---|---|---|
| | | Births | Deaths from | | | | | | |
| | | | All Causes | Tuberculosis of Respiratory System | Cancer | Heart Diseases | Bronchitis | Pneumonia | |
| 1948 | 178,100 | 21·12 | 11·81 | 0·78 | 2·16 | 2·44 | 1·14 | 0·48 | 41·74 |
| 1949 | 178,900 | 20·28 | 13·06 | 0·63 | 2·00 | 3·13 | 1·45 | 0·71 | 53·20 |
| 1950 | 177,700 | 18·87 | 12·87 | 0·50 | 2·31 | 3·51 | 1·30 | 0·46 | 42·93 |
| 1951 | 176,800 | 17·48 | 14·12 | 0·46 | 2·15 | 4·04 | 1·78 | 0·50 | 34·62 |
| 1952 | 176,400 | 15·57 | 12·19 | 0·35 | 2·12 | 3·35 | 1·33 | 0·59 | 34·52 |
| Average 5 years | | **18·66** | **12·81** | **0·54** | **2·15** | **3·29** | **1·40** | **0·55** | **41·40** |
| 1953 | 173,900 | 17·05 | 12·36 | 0·29 | 2·24 | 3·24 | 1·59 | 0·74 | 32·05 |
| 1954 | 171,500 | 16·72 | 11·98 | 0·23 | 2·39 | 3·44 | 1·19 | 0·56 | 30·35 |
| 1955 | 169,300 | 15·95 | 12·30 | 0·22 | 2·08 | 3·46 | 1·33 | 0·78 | 30·00 |
| 1956 | 167,400 | 16·88 | 12·34 | 0·20 | 2·43 | 3·48 | 1·46 | 0·78 | 29·37 |
| 1957 | 165,300 | 18·31 | 12·97 | 0·19 | 2·44 | 3·75 | 1·37 | 0·79 | 28·75 |
| Average 5 years | | **16·98** | **12·39** | **0·23** | **2·32** | **3·47** | **1·39** | **0·73** | **30·10** |
| 1958 | 163,600 | 17·91 | 13·20 | 0·12 | 2·20 | 3·70 | 1·56 | 0·84 | 28·67 |
| 1959 | 162,000 | 18·27 | 13·01 | 0·19 | 2·43 | 3·78 | 1·31 | 0·78 | 23·99 |
| 1960 | 161,170 | 18·56 | 12·67 | 0·13 | 2·44 | 3·60 | 1·21 | 0·62 | 26·75 |
| 1961 | 154,910 | 19·45 | 13·96 | 0·14 | 2·39 | 3·74 | 1·56 | 0·84 | 28·16 |
| 1962 | 154,000 | 20·77 | 14·90 | 0·08 | 2·42 | 4·23 | 1.67 | 0·91 | 29·07 |
| Average 5 years | | **18·99** | **13·55** | **0·13** | **2·37** | **3·81** | **1·46** | **0·79** | **27·33** |
| 1963 | 152,570 | 20·67 | 13·29 | 0·06 | 2·41 | 3·38 | 1·42 | 1·15 | 31·07 |
| 1964 | 150,350 | 20·31 | 12·26 | 0·07 | 2·38 | 3·51 | 1·17 | 0·71 | 30·46 |
| 1965 | 148,260 | 20·60 | 12·97 | 0·05 | 2·58 | 3·84 | 1·19 | 0·78 | 26·20 |

## TABLE 3

STATEMENT SHOWING NUMBER OF DEATHS IN THE CITY OF SALFORD FROM THE DISEASES SPECIFIED REGISTERED DURING THE YEARS 1933-1965 AND THE RATES PER 100,000 OF THE POPULATION.

(a) Number of Deaths. (b) Rate per 100,000 of the population.

| Year | Bronchitis | | Cancer (all sites) | | Heart Diseases | | Pneumonia | | Tuberculosis of Resp. system | | Total Deaths | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | (a) | (b) | (a) | (b) | (a) | (b) | (a) | (b) | (a) | (b) | (a) | (b) |
| 1933 | 200 | 92·2 | 339 | 156·2 | 591 | 272·4 | 269 | 124·0 | 248 | 116·0 | 3009 | 1386·6 |
| 1934 | 133 | 62·2 | 400 | 187·1 | 637 | 297·9 | 243 | 113·6 | 201 | 94·0 | 2932 | 1371·1 |
| 1935 | 131 | 62·4 | 348 | 165·7 | 656 | 312·4 | 236 | 112·4 | 190 | 90·5 | 2734 | 1301·9 |
| 1936 | 154 | 74·8 | 352 | 170·9 | 729 | 353·9 | 249 | 120·9 | 207 | 100·5 | 2893 | 1404·4 |
| 1937 | 141 | 69·9 | 390 | 193·3 | 779 | 386·0 | 245 | 121·4 | 178 | 88·2 | 2943 | 1458·4 |
| 1938 | 86 | 43·1 | 344 | 172·5 | 691 | 346·5 | 210 | 105·3 | 192 | 96·3 | 2611 | 1309·4 |
| 1939 | 92 | 46·8 | 366 | 186·2 | 838 | 426·2 | 201 | 102·2 | 187 | 95·1 | 2698 | 1372·3 |
| 1940 | 535 | 308·9 | 342 | 197·5 | 754 | 435·3 | 221 | 127·6 | 195 | 112·6 | 3224 | 1861·4 |
| 1941 | 333 | 208·5 | 276 | 172·8 | 559 | 350·0 | 211 | 132·1 | 173 | 108·3 | 2743 | 1717·4 |
| 1942 | 239 | 155·9 | 387 | 219·8 | 462 | 301·4 | 129 | 84·1 | 146 | 95·2 | 2223 | 1450·1 |
| 1943 | 330 | 215·7 | 345 | 225·5 | 445 | 290·8 | 147 | 96·1 | 148 | 96·7 | 2382 | 1556·9 |
| 1944 | 271 | 173·9 | 328 | 200·5 | 461 | 295·9 | 101 | 64·8 | 151 | 96·9 | 2271 | 1457·6 |
| 1945 | 416 | 264·5 | 313 | 199·0 | 472 | 300·1 | 126 | 80·1 | 146 | 92·8 | 2459 | 1563·3 |
| 1946 | 289 | 170·5 | 326 | 192·4 | 444 | 262·0 | 127 | 74·9 | 122 | 72·0 | 2266 | 1337·1 |
| 1947 | 288 | 165·5 | 351 | 201·6 | 488 | 280·3 | 122 | 70·1 | 131 | 75·3 | 2312 | 1328·2 |
| 1948 | 203 | 114·0 | 385 | 216·2 | 434 | 243·7 | 86 | 48·3 | 139 | 78·0 | 2103 | 1180·8 |
| 1949 | 260 | 145·3 | 358 | 200·1 | 560 | 313·0 | 127 | 71·0 | 113 | 63·2 | 2337 | 1306·3 |
| 1950 | 231 | 130·0 | 410 | 230·7 | 624 | 351·2 | 82 | 46·2 | 89 | 50·1 | 2288 | 1287·6 |
| 1951 | 314 | 177·6 | 392 | 221·7 | 715 | 404·4 | 89 | 50·3 | 82 | 46·4 | 2497 | 1412·3 |
| 1952 | 235 | 133·2 | 374 | 212·0 | 591 | 335·0 | 104 | 59·0 | 61 | 34·6 | 2151 | 1219·4 |
| 1953 | 277 | 159·3 | 390 | 224·3 | 563 | 323·7 | 129 | 74·2 | 50 | 28·8 | 2149 | 1235·8 |
| 1954 | 204 | 119·0 | 410 | 239·1 | 590 | 344·0 | 96 | 56·0 | 39 | 22·7 | 2055 | 1198·3 |
| 1955 | 226 | 133·5 | 352 | 207·9 | 585 | 345·5 | 132 | 78·0 | 38 | 22·4 | 2082 | 1229·8 |
| 1956 | 244 | 145·8 | 407 | 243·1 | 583 | 348·3 | 131 | 78·3 | 33 | 19·7 | 2065 | 1233·6 |
| 1957 | 226 | 136·7 | 404 | 244·4 | 620 | 375·1 | 131 | 79·3 | 31 | 18·8 | 2150 | 1300·7 |
| 1958 | 255 | 155·9 | 359 | 219·4 | 611 | 370·4 | 137 | 83·7 | 20 | 12·2 | 2159 | 1319·7 |
| 1959 | 212 | 130·9 | 394 | 243·2 | 612 | 377·8 | 127 | 78·4 | 31 | 19·1 | 2107 | 1300·6 |
| 1960 | 195 | 121·0 | 393 | 243·8 | 580 | 359·9 | 100 | 62·0 | 21 | 13·0 | 2042 | 1267·0 |
| 1961 | 242 | 156·2 | 370 | 238·8 | 579 | 373·8 | 130 | 83·9 | 21 | 13·5 | 2163 | 1396·0 |
| 1962 | 258 | 167·5 | 374 | 242·9 | 651 | 422·5 | 141 | 91·6 | 13 | 8·4 | 2294 | 1489.6 |
| 1963 | 216 | 141·6 | 367 | 240·5 | 516 | 338·2 | 176 | 115·3 | 10 | 6·5 | 2028 | 1329·2 |
| 1964 | 176 | 117·1 | 358 | 238·1 | 528 | 351·2 | 106 | 70·5 | 11 | 7·3 | 1844 | 1226·5 |
| 1965 | 176 | 118·7 | 383 | 258·3 | 569 | 383·8 | 116 | 78·2 | 7 | 4·7 | 1923 | 1297·0 |

**CAUSES OF DEATH** – Registrar General's Return of Deaths in the City of Salford during the year 1965

| CAUSE OF DEATH | Sex | Total All ages | Under 4 weeks | 4 weeks & under 1 year | AGE IN YEARS 1– | 5– | 15– | 25– | 35– | 45– | 55– | 65– | 75 and over |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Tuberculosis, Respiratory | M | 5 | – | – | – | – | – | – | 1 | – | 3 | 1 | – |
| | F | 2 | – | – | – | – | – | – | – | – | – | 1 | 1 |
| 2. Tuberculosis, Other | M | 1 | – | – | – | – | – | – | – | 1 | – | – | – |
| | F | 2 | – | – | – | – | – | – | 1 | – | 1 | – | – |
| 3. Syphilitic Disease | M | 1 | – | – | – | – | – | – | – | – | – | 1 | – |
| | F | 3 | – | – | – | – | – | – | – | – | – | 1 | 2 |
| 6. Meningococcal Infections | M | – | – | – | – | – | – | – | – | – | – | – | – |
| | F | 2 | – | – | 2 | – | – | – | – | – | – | – | – |
| 9. Other Infective & Parasitic Diseases | M | 1 | – | 1 | – | – | – | – | – | – | – | – | – |
| | F | 2 | – | – | – | – | – | – | 1 | – | – | – | 1 |
| 10. Malignant Neoplasm, Stomach | M | 31 | – | – | – | – | – | – | 1 | 1 | 8 | 9 | 12 |
| | F | 18 | – | – | – | – | – | – | – | 2 | 3 | 5 | 8 |
| 11. Malignant Neoplasm, Lung, Bronchus | M | 109 | – | – | – | – | – | – | 3 | 16 | 51 | 27 | 12 |
| | F | 14 | – | – | – | – | – | – | – | 4 | 3 | 7 | – |
| 12. Malignant Neoplasm, Breast | M | 2 | – | – | – | – | – | – | – | – | 1 | – | 1 |
| | F | 46 | – | – | – | – | – | – | 5 | 10 | 12 | 10 | 9 |
| 13. Malignant Neoplasm, Uterus | F | 10 | – | – | – | – | – | – | 1 | 1 | 4 | 2 | 2 |
| 14. Other Malignant & Lymphatic Neoplasms | M | 85 | – | – | – | – | 1 | 2 | 2 | 15 | 19 | 23 | 23 |
| | F | 68 | – | – | – | 1 | – | 1 | – | 9 | 15 | 18 | 24 |
| 15. Leukaemia, Aleukaemia | M | 2 | – | – | – | 1 | – | – | – | – | 1 | – | – |
| | F | 3 | – | – | – | 1 | – | – | – | – | 1 | 1 | – |
| 16. Diabetes | M | 6 | – | – | – | – | – | – | – | – | – | 5 | 1 |
| | F | 10 | – | – | – | – | – | – | – | – | 1 | 5 | 4 |
| 17. Vascular Lesions of Nervous System | M | 98 | – | 1 | – | – | – | – | 1 | 9 | 25 | 25 | 37 |
| | F | 139 | – | – | – | – | – | – | 2 | 6 | 18 | 45 | 68 |
| 18. Coronary Disease, Angina | M | 217 | – | – | – | – | – | 2 | 9 | 37 | 78 | 66 | 25 |
| | F | 161 | – | – | – | – | – | – | 3 | 9 | 27 | 50 | 72 |
| 19. Hypertension with Heart Disease | M | 5 | – | – | – | – | – | – | 1 | 1 | 1 | 1 | 1 |
| | F | 14 | – | – | – | – | – | – | – | 1 | 1 | 4 | 8 |

**CAUSES OF DEATH — Registrar General's Return of Deaths in the City of Salford during the year 1965 *(continued)***

| CAUSE OF DEATH | Sex | Total All Ages | Under 4 weeks | 4 weeks & under 1 year | AGE IN YEARS 1– | 5– | 15– | 25– | 35– | 45– | 55– | 65– | 75 and over |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 20. Other Heart Diseases | M | 50 | – | – | – | – | – | 1 | 1 | 3 | 10 | 16 | 19 |
| | F | 122 | – | – | – | – | 1 | 1 | 3 | 1 | 18 | 26 | 72 |
| 21. Other Circulatory Disease | M | 18 | – | – | – | – | – | – | – | – | 7 | 4 | 7 |
| | F | 37 | – | – | – | – | – | – | – | 3 | 5 | 4 | 25 |
| 22. Influenza | M | 2 | – | – | – | – | – | 1 | – | – | – | 1 | – |
| | F | – | – | – | – | – | – | – | – | – | – | – | – |
| 23. Pneumonia | M | 48 | 2 | 9 | 1 | – | 1 | – | – | 3 | 6 | 10 | 16 |
| | F | 68 | 1 | 9 | 1 | – | – | – | – | 3 | 4 | 11 | 39 |
| 24. Bronchitis | M | 109 | – | 1 | – | – | – | – | – | 10 | 30 | 38 | 30 |
| | F | 67 | – | – | – | – | – | – | – | 4 | 7 | 21 | 35 |
| 25. Other Diseases of Respiratory System | M | 8 | – | 1 | – | – | – | – | – | 1 | – | 2 | 4 |
| | F | 7 | – | – | – | – | – | – | 1 | – | 1 | – | 5 |
| 26. Ulcer of Stomach and Duodenum | M | 8 | – | – | – | – | – | 1 | 1 | 1 | 3 | – | 2 |
| | F | 7 | – | – | – | – | – | – | – | – | 1 | 2 | 4 |
| 27. Gastritis, Enteritis and Diarrhoea | M | 3 | 1 | – | 1 | – | – | – | – | – | – | – | 1 |
| | F | 9 | – | 1 | – | – | – | – | – | 1 | 2 | 3 | 2 |
| 28. Nephritis and Nephrosis | M | 4 | – | – | 1 | – | – | – | – | 1 | 2 | – | – |
| | F | 3 | – | – | – | – | 1 | 1 | – | – | – | – | 1 |
| 29. Hyperplasia of Prostate | M | 7 | – | – | – | – | – | – | – | – | 1 | 1 | 5 |
| 30. Pregnancy, Childbirth, Abortion | F | 1 | – | – | – | – | – | – | 1 | – | – | – | – |
| 31. Congenital Malformations | M | 5 | 4 | – | – | – | – | – | – | 1 | – | – | – |
| | F | 5 | 2 | 2 | – | – | – | – | – | – | 1 | – | – |
| 32. Other Defined & Ill-Defined Diseases | M | 75 | 25 | – | – | – | – | 2 | 2 | 4 | 5 | 12 | 25 |
| | F | 113 | 18 | 1 | – | – | 2 | 2 | 3 | 7 | 12 | 11 | 57 |
| 33. Motor Vehicle Accidents | M | 18 | – | – | 1 | 4 | 6 | 2 | 1 | 1 | 1 | 1 | 1 |
| | F | 11 | – | – | 1 | – | 1 | – | 3 | 1 | – | 1 | 4 |
| 34. All Other Accidents | M | 20 | – | – | 1 | 4 | 3 | 4 | 1 | 3 | – | 1 | 3 |
| | F | 27 | – | 1 | – | 1 | 1 | – | – | – | 1 | 6 | 17 |
| 35. Suicide | M | 10 | – | – | – | – | – | 2 | 3 | 2 | 1 | 2 | – |
| | F | 4 | – | – | – | – | – | – | 1 | 1 | 2 | – | – |
| TOTAL ALL CAUSES | M | 948 | 32 | 13 | 5 | 9 | 11 | 17 | 27 | 110 | 253 | 246 | 225 |
| | F | 975 | 21 | 14 | 4 | 3 | 6 | 5 | 25 | 63 | 140 | 234 | 460 |

# ENVIRONMENTAL HYGIENE

The face of Salford is changing, slowly but nevertheless steadily and the pace of change is quickening as it must do if our City is to maintain its traditionally important place in the North West. The old areas of congested century-old houses with their problems of disrepair and dilapidation, extensive dampness and overshadowing allied to an almost total lack of modern amenities are giving place to new homes in flats, maisonettes or modern terraces with easy access, open space, play and recreational facilities and the convenience and amenities of modern homes. Shopping areas, planned for convenience and for the segregation of traffic from the shopper, will take over eventually from the multitude of corner shops and the shop frontages of major traffic routes.

Added to the spectacular evidence of Salford's clearance and redevelopment programmes is the growing success of our plans for improving the amenities of houses not scheduled for clearance, both in selected improvement areas and as individual properties. Perhaps, in the near future it will be possible to integrate into an improvement area, specific plans for the brightening of the general environment, for the gay external painting of homes, so much a feature of many continental towns, by tree planting, by new street furniture, by new parking facilities, and dare we ever hope, by the imaginative and colourful use of small open spaces. It is surely wrong to assume that a modern and pleasant environment can only be provided in our newly developed areas.

Also in smoke control the improvement is considerable and it is interesting to note that the atmosphere in Salford is now approximately twice as clean as it was five years ago. It is hoped that, as mentioned in the following pages, all consumers and suppliers will co-operate in this essential part of environmental hygiene.

## HOUSING: SLUM CLEARANCE AND IMPROVEMENT

The year 1965 showed, once again, a notable step forward in our campaign for the clearance of unfit houses. The annual target of 1,500 unfit houses to be represented for clearance procedure was handsomely exceeded by over 200 properties and the number of additional houses subject to individual action for either demolition or closure was higher than ever before.

The following tables give factual details of the numbers of properties subject to specified action in our overall clearance programme. It is important to realise that at every step in our clearance programme we are dealing not only with houses but with people, with individual family units each with their own particular problems and likes and dislikes. That we succeed in the physical uprooting and rehousing of so many families each year without serious criticism is a tribute to the commonsense and practical approach of all officers concerned with all the varied aspects of clearance and rehousing.

**Clearance Areas Represented During 1965**

| Area | No. of dwellings | Type of Area |
|---|---|---|
| Clarendon Road Clearance Area No. 1 | 458 | Immediate demolition |
| Do. No. 2 | 248 | Do. |
| Do. No. 3 A. B. C. | 144 | Do. |
| Albany St./Bishop St. Clearance Area | 48 | Do. |
| Great Clowes St. Clearance Areas Nos. 1 & 2 | 11 | Do. |
| Lower Broughton Road (Nos. 250/252) Clearance Order | 2 | Do. |
| Ellor Street No. 9 Clearance Area | 182 | Do. |
| Flax Street Clearance Area | 23 | Do. |
| Devonshire Street Clearance Area | 6 | Do. |
| Whit Lane Clearance Areas Nos. 3A. B. C. D. E. F. | 608 | Deferred demolition |
| Do. Nos. 3G. H. | 32 | Do. |
| Total Properties | 1,762 | |
| Additional house and house/shop properties associated with Clearance Areas and included within the relevant compulsory purchase orders | 46 | |
| Total | 1,808 | |

**Orders Confirmed During 1965 (Compulsory Purchase Orders)**

| Area | No. of Dwellings | Action following Confirmation |
|---|---|---|
| Whit Lane Nos. 1A. B. C. (Deferred Areas) | 447 | Entry for patch maintenance and selective closure or demolition |
| High St. Nos. 1A. B. C. D. E. F. (Immediate Areas) | 501 | Entry. Rehousing and demolition commenced |
| Whit Lane Nos. 2A. B. C. D. E. F. (Deferred Areas) | 399 | Entry for patch maintenance and selective closure or demolition. |
| Flax Street (Immediate Area) | 23 | Entry to be effected early 1966 |
| Total Properties | 1,370 | |

**Unfit Houses Demolished or closed during 1965 (involving family rehousing) and including Individually Unfit Properties**

| Period | Dwellings | Persons |
|---|---|---|
| 1st Quarter 1965 | 426 | 1,191 |
| 2nd Quarter 1965 | 282 | 941 |
| 3rd Quarter 1965 | 185 | 650 |
| 4th Quarter 1965 | 356 | 1,145 |
| Totals | 1,249 | 3,927 |

In addition 30 other families from clearance areas found their own accommodation.

Public local inquiries into 16 separate clearance areas in 4 compulsory purchase orders involving 1,370 separate dwellings were held during the year.

Senior public health inspectors (2) were responsible for the preparations of the official representations, gave detailed evidence of the properties which were subject to objection and accompanied the Ministry Inspector to the properties concerned.

**Rehousing (Removal and Disinfestation)**

The removal of all household furniture and effects of families from Clearance Areas and from individually unfit houses is undertaken by the Corporation free of charge to the families concerned but in all cases of removal to Corporation owned accommodation the Council insists that all furniture is disinfested prior to removal. Disinfestation by the use of residual insecticides is carried out by trained operatives of the Health Department's disinfestation service who also treat the fabric of the buildings before demolition.

**Immediate Demolition Areas**

Rehousing of all families from houses in Immediate Demolition Clearance Areas is carried out within a period of twelve months from entry upon the area.

Inevitably conditions in clearance areas deteriorate rapidly once families start being moved out. It is particularly difficult to ensure that the essential services of gas, electricity and water are maintained to all occupied houses and serious and almost uncontrollable vandalism by children as well as adults creates many problems as well as leaving potentially dangerous playgrounds for children of the neighbourhood. There is always the ever present fear that a child may be injured or killed playing in the empty houses and a special plea is made to all parents to forbid their children to play in the empty property in Clearance Areas.

In an endeavour to minimise serious nuisances and discomfort for families awaiting rehousing a simple system of emergency repairs has been evolved which enables roofs to be made weatherproof, water supplies reconnected and other necessary works carried out speedily at minimum cost.

To reduce charges upon vacation of properties cut off teams from the gas and electricity undertakings operate on a permanent basis in the clearance areas and their controlling offices are notified by telephone in advance of the dates of vacation.

**Deferred Demolition (Sec. 48 Housing Act, 1957)**

The acquisition of substantial numbers of properties for deferred demolition is an essential element in Salford's plans for the eventual clearance of unfit houses. The overall scheme involves the selective closure or demolition of properties allied to the patch maintenance of the balance and the deferment of demolition for a period of about seven years.

In general the system works well and permits of the rapid closure or demolition of houses which are incapable of being made even tolerable for the time being, together with the carrying out of an extensive programme of patch maintenance works designed, not to make the properties fit, but to reduce discomfort and serious nuisance during the period of deferment of demolition.

After confirmation of the compulsory purchase order and entry upon the properties they come under the control of the Housing Committee and are managed in all respects by the Housing Manager. Prior to entry, detailed schedules of repair and recommendations for closure or demolition are prepared by the Housing Section of the Public Health Inspectorate and are handed to the Housing Manager for implementation.

The success or failure of any programme for the deferred demolition acquisition of houses under Clearance Area programmes depends to a very large extent on a close and active co-operation between the staffs of the Housing Department and the Health Department. Only if the very bad properties are closed or demolished speedily and the programme of patch maintenance commenced immediately upon entry, can the system work successfully.

**Improvement Areas**

Continuing the policy and programme of enforcing the provisions of the Housing Act 1964 for the provision of amenities of baths, wash hand basins, hot and cold water supplies, internal water closets (where practicable) and facilities for storing food, two further improvement Areas were defined and another was represented and is awaiting Council approval.

| | Defined | No. of Properties | Already Improved | O/Occ | Tenanted |
|---|---|---|---|---|---|
| Lower Broughton (No. 1. Grecian St.) | 6. 1. 65 | 239 | 5 | 85 | 154 |
| Langworthy No. 1 | 28. 7. 65 | 326 | – | 91 | 235 |
| Duchy Road | Awaiting Approval | 115 | 10 | 46 | 69 |

The lengthy and complicated procedure for enforcement of the necessary Improvement, together with negotiations with owners on a voluntary basis were undertaken in respect of these areas and the Seedley Nos. 1 and 2 Improvement Areas which were defined earlier.

The progress achieved up to 31st December 1965 in each area is shown below.

| | No. of Properties | Already Improved | Under-takings | Improvements completed | Applications for Grants | Premises subject to Statutory Notice |
|---|---|---|---|---|---|---|
| Seedley No. 1 | 254 | 20 | – | 75 | 102 | – |
| Seedley No. 2 | 206 | 48 | – | 43 | 64 | – |
| Lr. Broughton (Grecian St.) | 239 | 5 | 49 | 17 | 29 | 72 |
| Langworthy No 1 | 326 | – | – | 2 | 8 | 168 |
| Duchy Rd. | 115 | 10 | – | – | 2 | – |

### Representations from Tenants outside Improvement Areas

During the year representations were received from 25 tenants of dwellings outside improvement Areas for the Council to enforce improvements. These were acknowledged and the necessary procedures instigated to effect compulsory improvement.

10 applications for grant assistance were received following formal action on receipt of Tenants representation.

### Improvement Grants

The number of grant applications rose slightly over the previous year and 219 applications were approved. Inspections of works in progress and on completion resulted in grant payment of £16,285 being made in respect of 197 dwellings.

The success of the Council's Improvement programme is dependent upon the support of tenants and the encouragement of owner/occupiers and owners as well as upon the physical limitations of existing staff resources. Consequently publicity and advertisement of the effects, benefits and provisions of the Council's policy and grant assistance are of the utmost importance and were incorporated into the programme as follows :–

(a) A Salford Improvement Grant handbook was produced by a commercial publisher and financed by local advertisements. These handbooks were distributed to all owners and occupiers with the defined improvement areas and to individuals on request.

(b) The Ministry of Housing and Local Government mobile exhibition visited Salford, was stationed at Cross Lane Market, Langworthy Road Clinic and Albert Park. Many hundreds of people visited the exhibition during its two weeks stay and expressed their support for the legislation and the Council's action.

(c) Posters and leaflets in shop and Public Departments.

### Future Progress

Further improvement areas will be represented in 1966 and it is hoped that the accumulative results of many Improvement Areas will help to achieve our target of 500 houses improved per year.

Salford is one of the very few local authorities pioneering in this field of housing and is in constant liaison with the Ministry of Housing and Local Government on means of simplifying the legislative procedures so that as many as possible of our citizens may enjoy the nationally accepted basic necessities of 20th Century accommodation.

## DRAINS AND SEWERS

Inspections carried out on Drains and Sewers during the year totalled 2,805, and from this total 335 were in respect of drains on Corporation property managed by the Housing Department. Simple blockages were dealt with as in the past, by rodding or plunging and no charge made for the service rendered.

In addition to inspection of blockages, numerous complaints of percolations were received during the year. These were usually found in cellars, basements and sub-floor cavities. Colour testing of the drains was carried out to ascertain if the cause was a defective drain and the assistance of Manchester Water Department is sought to test water mains when a negative result is obtained. In one instance a complaint was received from an occupier in a terraced house of water percolating into the cellar. Colour testing of the drains was carried out at the house and also on adjoining houses. Out of eleven houses colour tested, five were found to have defective drains and each one gave a colour reaction in the cellar of original complaint. Notices were served upon the landlords and owner/occupiers and the drains were opened up. In some cases only small defects were found but in one case it was found that all the drains were broken and the only remedy was to renew the whole drain.

Several complaints of sewer gas were received during the Autumn and it was found that the majority of complaints were coming from a small area close to the Gas Works. By arrangement with the Trade Effluent Inspector and the Chemist and Engineers from the Gas Works, an inspection was made of the drains and drain outfall into the Public Sewer. It was found that the water from the Phimax Cooling Plant was not being sufficiently cooled, before passing from the "Holding Tanks" into the Public Sewer. This has now been rectified and no further complaint of sewer gas has been received from the area. Isolated complaints of sewer gas were found on smoke testing the drains to be caused by a broken or defective drain. In one case a complaint of smell was investigated and found to be coming from two dead rats behind a partition.

In respect of notices served under Section 39 of the Public Health Act relating to defective drains work was carried out in default at twenty four premises and the total cost of this work was £342. which is recoverable from the owners of the property concerned.

Notices were issued in respect of 55 sewers under Section 24 of the Public Health Act, and the necessary work was carried out by the City Engineer. The Highways Dept. and Drainage Inspector co-operate in carrying out this work.

Contractors usually co-operate very well in carrying out work on drains and advice is often sought in carrying out this work. The Drainage Inspectors assistance is always available and especially where serious defects exist requiring the reconstruction of a drainage system.

## SMOKE CONTROL AREAS

The making of smoke control orders by local authorities is a matter which has caused considerable concern to successive Ministers of Housing and Local Government. From time to time local authorities are urged to accelerate their programmes and to facilitate this, the administrative arrangements have been simplified. There have been many changes in the administration of Smoke Control since the first orders were made. In those days more Staff were required for the compilation of the various forms and records required by the Ministry of Housing and Local Government than to initiate and ensure the completion of the actual fireplace adaptations.

Many local authorities are involved in smoke control in the built up areas, such as the Special review areas, where the built up part of one local authority adjoins a similar area of another local authority. Contractors in such areas will work in the district of several local authorities and it is also inevitable that the residents in one area will shop and have friends or relations in the district of another. Smoke control cannot therefore be carried out in isolation. Co-operation and joint action in respect of the creation of smoke control areas at the boundaries of the adjoining local authorities is desirable but even more important is a unified grant system, a standardised procedure for the making of orders and dealing with properties located in Smoke Control areas, and the use of similar forms by all local authorities.

The Minister has gone a little way in this matter in making a price range for appliances but this is still inadequate and there are still anomalies to be rectified. Probably the best way to deal with Smoke control administration is for groups of nearby local authorities to meet and formulate standardised prices for the various types of adaptations which may be carried out using the various types of approved appliances, to devise a standard procedure for dealing with smoke control and to design the various forms etc., usually found to be required. This will simplify matters for all contractors and eliminate discontent caused by variations in grant payment for similar work in different local authority areas, it will also facilitate the formulation of an efficient Scheme of grant assignment which is vital for the success in any Smoke Control Programme. Above all in these days of competition for building trade labour it will encourage contractors to undertake the work in Smoke Control Areas.

One anomaly created by the Ministry the reasoning of which is difficult to understand or explain away is the varying grant payment when central heating is installed. The Ministry require the grant to be based on the type of fuel used in the boiler, for example where gas or oil fired central heating is installed the grant is based on the national cost of gas fires or oil heaters in each room where an existing coal burning fireplace was in regular use. Grant is not payable on the boiler itself but only on the notional cost of a gas fire or oil heater. For solid fuel, the cost of the boiler is grant aided and the other rooms on which there is a coal fire in regular use are grant aided on the notional cost of installing an improved open grate or where justified an under-floor draught fire. This line of reasoning is unnecessary, inequitable, introduces complications and can give rise to resentment from the residents. It represents muddled, inconsistent and quite fallacious thinking. If the grant structure is being simplified a standard cost for all boilers and radiators replacing coal fires is essential. Notional costs have their uses at times, but calculations for central heating on the present basis is not one of those times.

### The Distribution of Solid Smokeless Fuels

In Smoke control areas the fuels used must be authorised fuels and the emission of smoke due to the burning of a fuel other than an authorised one constitutes an offence. Many of the larger dealers carry a wide range of the various Solid Smokeless Fuels and the residents patronising such dealers have a corresponding wide choice of fuel. Not so fortunate are those who deal with a small merchant who is unable to carry any stock and usually handles one, or at the most, two of the smokeless fuels. Such trading necessitates

daily collection from the supplier and with ever growing Smoke control areas the congestion and delays at the supplier's premises must inevitably increase. When it is not expedient to collect or when there are delays in collection these traders will not have any solid smokeless fuel. Far too frequently are customers of this type of merchant told that there is no smokeless fuel available or that smokeless fuel is in short supply or that they will have to burn coal because there is no smokeless fuel. These excuses are of course quite false but the purchaser rarely attempts to ascertain the accuracy of such statements and is faced with the necessity to obtain fuel and consequently another unnecessary smoke control contravention occurs.

This situation arises because of the type of business and the method of trading in which the fuel must be collected daily in bags. As further areas become subject to smoke control the demand by dealers for bagged fuel rises and it is obvious that demand must outstrip availability because of the limitations associated with bagging. Either the smaller dealers must unite to form their own "joint supply stockpile" of fuels and a joint bagging plant or they must give way to the larger merchants. These traders must be firmly handled and discouraged from giving false information regarding the non-availability of smokeless fuel thereby forcing coal on to the consumer.

Even worse is the type of merchant who deliberately touts coal around a smoke control area. It is easy to say that the offence is emitting smoke caused by burning coal but this is merely avoiding the real issue and the real problem. If coal is deliberately touted or forced by specious means on to a consumer then the seller is morally guilty of an offence more serious than that of the user. It should be possible to deal with smoke control problems without having to threaten or resort to prosecutions against residents. An amendment to the Clean Air Act 1956 making the sale of coal in a Smoke Control area an offence is very necessary if these practices are to be extinguished. The fuel trade organisations and the National Coal Board cannot evade responsibility for the problem and for the inertia and complacency they have displayed in dealing with it. The trade organisations can warn their members of the consequences whilst the National Coal Board can prevent offending merchants from purchasing coal. Since the National Coal Board control the supply of coal and has initiated the Diploma and Approved Merchants Scheme it is a simple matter to control distribution and ensure coal is not supplied to offending merchants.

Smoke control is neither a game or the pursuit of idealists, it is a very vital health measure. With the areas covered by Smoke Control orders becoming increasingly larger the bodies involved in the fuel trade particularly the National Coal Board must take a more active part and not act in the manner of a modern Pontius Pilate.

### Railway Engines

The Clean Air Act came into force in 1956 which is just ten years ago. It is rather surprising to know that coal-fired railway engines were still being constructed long after this date. There is a specific section in the Clean Air Act 1956 which applies to railway engines and which makes the emission of smoke from an engine an offence in the same manner as smoke from the chimney of a building. The fact that railway engines are specifically mentioned in the Act should have been of sufficient significance to British Railways

for a rapid change to other forms of traction. It would seem reasonable to assume that steam powered engines operating in the black areas, particularly goods and shunting engines used in heavily built up areas would be the first to necessitate replacement. Unfortunately it did nothing of the sort and this merely confirmed that the nationalised railway industry is rather out of touch with the opinions of local authorities and is continuing to fall short of legislative requirements and public opinion. It would appear that the railways have avoided many prosecutions because of the tolerance and good will of Local Authorities. Much has been achieved on the passenger side but there are still many replacements needed particularly for goods and shunting. This may arise from indifference to the urgent need for replacement of goods and shunting engines or over emphasis of the priority accorded to passenger engines.

Electric engines are completely smokeless in operation whilst diesels are virtually smokeless and moreover drivers find such engines cleaner and easier to operate, the footplate staff are less exposed to the weather and they are quieter than coal-fired steam trains.

Goods and marshalling yards where shunting is regularly carried out are a continual source of nuisance and annoyance to the nearby residents from the heavy emissions of smoke, grit and the noise arising from such operations. People who are unfortunate enough to live near to main lines on which steam trains travel are also subjected to smoke and grit, particularly if signals are nearby, or if there is much goods traffic.

Smoke and grit are virtually unavoidable where coal fired engines are used for shunting and goods trains and when it is considered that this occurs daily throughout the year, the patience of both residents and the local authorities is stretched to breaking point. The Railways in common with other large employers cannot now pick and choose their staff with the same care as in earlier years, so that the efficiency of firing and achieving of the best possible combustion is dependent upon the efficiency of the footplate staff. Granted the railways do train and issue a booklet to the footplate staff on good firemanship but the results from this are directly related to the extent to which the information contained is put into practice. In many cases even with good firemanship it is just not possible to achieve the desired results.

The clearing of slum properties, the massive redevelopment taking place throughout the country, the increasing urbanisation and extending smoke control areas will in the space of a few years transform these areas into delightful well planned modern towns and cities. The continued use of coal fired engines is a direct indictment of the railways failure to plan and programme for their replacement by electric or diesel engines which in the case of engines used in marshalling or goods yards should by now have been completed. It should not be necessary with nationalised industry to force this replacement by prosecution.

We have progressed far since the days of George Stephenson and his famous engine "The Rocket" but this progress has not been matched by the railways to the extent to which it is necessary and desirable. If this cannot be achieved on a voluntary basis then clearly Ministry intervention is indicated.

**Chimney Heights**

The Clean Air Act 1956 gave power to control the height of chimneys but exempted buildings used as offices, shops or residences. The modern practice of constructing large blocks of flats which may have twenty or more storeys, large office blocks of even greater height and shopping precincts has resulted in the heating appliances and the quantity of fuel used, being greater in the exempted buildings than in many of the buildings which fell within the scope of the Section. It is therefore of equal importance to control the dimensions and height of the chimney. Many developers and architects do seek local authority advice on heating installation, fuel proposed and chimneys, and it must be agreed that it is much simpler to amend a proposal than it is to alter a building because of complaints or nuisance.

Except so far as provision is made in Sec. 22 of the Clean Air Act 1956 Crown premises are exempt from the provisions of the Act. Sec. 71 Public Health Act 1936 exempts from the application of building byelaws, buildings belonging to statutory undertakers and school premises the plans of which have been approved by the Ministry of Education. This, of course, exempts such buildings from the provisions relating to chimney heights contained in the Clean Air Act. In the case of schools this exemption can lead to the County Council as Education Authority constructing a school in the district of a local authority, who can be overruled regarding the chimney height. The local authority will therefore have to accept whatever the architect proposes if persuasion fails. Further, the approval of school plans by the Ministry of Education results in a similar situation whereby a Ministry official can determine what is to be done in the district of a local authority.

It could be said that the exemptions conferred by Sec. 71 apply to responsible bodies who will fully comply with all relevant law. This, however, is unfortunately not so and one set of standards is applied to premises falling within Sec. 10 and whatever is proposed for exempted premises or what can be achieved by persuasion has to be accepted however reluctantly.

The intensive redevelopment being carried out and the amount of new building work makes it most important that all construction is approved regarding the heating plant and chimney. Local authorities and their residents have to live with these installations. Local authorities are answerable to their ratepayers and they should at least determine and approve such installations prior to erection.

There is no justification for any exemption of this nature from the provisions of an Act seeking to improve atmospheric conditions.

## FOOD HYGIENE

The majority of food premises in Salford now comply in most respects with the Food Hygiene (General) Regulation 1960, at least so far as the premises and equipment are concerned. This has come about largely as a result of the comprehensive survey work carried out in recent years, and latterly the continuing work done in connection with the Offices, Shops and Railway Premises Act 1963.

It should not be thought that this situation warrants complacency. The

problem is that the requirements of the Regulations do not approach the standards dictated by good practice, and in some respects fall below what is required to protect the public.

A notable instance of the inadequacy of the Regulations, is the lack of powers to control cooked meat displays which are frequently seen in shop windows and other places, where no attempt is made to control the temperature. It has been known for many years that if the temperature of cooked meats is kept below 45°F, the risk of food poisoning is reduced enormously. Despite this it is still common practice amongst the less enlightened traders, to display their foods in shop windows where high temperatures may be reached.

This peril has been taken up with many traders and some improvement has been effected during the year. In one particularly bad case the trader concerned has agreed to install a mechanically cooled display unit in one of his shops as a trial. It is hoped that further progress will be made by agreement, but stronger legal powers would be desirable, and were indeed recommended by the Milne Report on the Aberdeen Typhoid Outbreak.

Although the overall position is much improved, there are still a small number of premises where unwholesome conditions are regularly found. Such premises are kept on an accelerated visiting list in an attempt to achieve control. In three such cases during the year legal proceedings have been instituted for persistent contraventions of the Regulations, details being briefly as follows :–

(i) Summonses were issued against a retailer of poultry and eggs for carrying on business in insanitary premises. The Public Health Inspector was carrying out a routine inspection in the shop premises, when he noticed a foul smell coming from a rear room. He found a substantial quantity of decomposing chickens stored in close proximity to chickens intended for sale, and the general standard of hygiene was primitive. A fine of £70 was imposed by the Stipendiary Magistrate.

(ii) A Summons was issued against a grocer for failing to keep clean a food slicing machine, exposing food to the risk of contamination, and allowing refuse to accumulate in food rooms. A fine of £24 was imposed.

(iii) A Summons was issued against the occupier of a bakehouse for carrying on business in insanitary premises. The case arose out of complaints from neighbouring tradesmen that they were invaded by cockroaches. The focus of the infestation was found in the bakehouse and the Public Health Inspector felt that it was largely due to the bad hygiene which had been the subject of previous warnings going back over a period of years. For eight contraventions involving lack of cleanliness, good order and repair a fine of £24 was imposed.

## MEAT INSPECTION

### Cheltenham Street Slaughterhouse

Manchester Meats Ltd. a company formed by three Manchester Meat Wholesalers opened the slaughterhouse on 17th September 1964, to provide a local meat market for Salford and surrounding districts.

The Meat Inspection Regulations 1963 give the local authority power to make charges in respect of meat inspection. The charges which are determined by the local authority shall not exceed :–

(a) 2/6d. for each bovine animal
(b) 9d. for each calf or pig
(c) 6d. for each sheep, lamb or goat

As is common with the majority of other local authorities in Lancashire, Salford Corporation impose the maximum charges.

### Carcases Inspected and Meat Condemned within the District

| | Bovines | Calves/ Pigs | Sheep/ Lambs |
|---|---|---|---|
| Number Killed | 1,303 | | 11,685 |
| Number Inspected | 1,303 | | 11,685 |
| All diseases except Cysticercus Bovis:– | | | |
| (a) Whole carcases condemned | 2 | | 24 |
| (b) Carcase of which some part of organ was condemned | 5 | | 31 |
| Cysticercus Bovis:– | | | |
| (a) Carcases of which some part or organ was condemned | 3 | | |
| (b) Carcases submitted to treatment by refrigeration | 3 | | |
| (c) Generalised and totally condemned | 1 | | |

### Weight of Meat and Offal Rejected from Animals Slaughtered

| | Tons | Cwts. | Qtrs. | Lbs. |
|---|---|---|---|---|
| Full carcases | | 15 | | 3 |
| Part carcases | | 10 | 1 | 9 |
| Offal | 2 | 8 | 1 | 27 |
| Total | 3 | 13 | 3 | 11 |

### Weight of Meat and Poultry rejected not Slaughtered on the Premises

| | | | | |
|---|---|---|---|---|
| Frozen Meat | | 2 | | 13 |
| Chickens/Rabbits | | 3 | 2 | 24 |
| Total | | 5 | 3 | 9 |

## SAMPLING UNDER THE FOOD AND DRUGS ACT 1955

706 samples were taken during the year. These were taken under the Food and Drugs Act, 1955, and were submitted for analysis by the City Analyst, who will give details of samples taken, and the results of analysis in his section of this report.

The samples included 317 milks taken at various distribution points throughout the City, i.e. Hospitals, Canteens, Shops, Dairies, Vending machines and Milk vehicles.

14 samples of drugs were taken from Chemists in the City. These are also included in the above figures.

Complaints were received throughout the year regarding foodstuffs purchased in the City, and when necessary were submitted to the City Analyst for his examination.

The complaints were mainly made for moulds, sourness, foreign bodies (including insects) and dirty containers. The majority of the complaints were justified and appropiate action was taken in each case.

Two prosecutions were taken during the year under Section 2 of the Food and Drugs Act, 1955:-

(1) A complaint was received that a large white loaf was purchased which had a large metal screw embedded in the centre of the loaf. The Bakery firm pleaded guilty and were fined £50 plus 10/-d costs.

(2) Several Sausage Rolls were purchased from a shop in the City in an advanced state of mould.
The Bakery concerned were subsequently fined £10 plus 24/-d costs.

## BACTERIOLOGICAL SAMPLING OF FOODSTUFFS

### Ice Cream

Fifty-seven samples of ice cream were taken from manufacturers and vendors in the City. Seven of the samples were reported as unsatisfactory according to provisional grading of the Public Health Laboratory Service, who carried out the examination.

Visits were made to all manufacturers and advice and information given when necessary. It is stressed that a high standard of hygiene, particularly personal hygiene is necessary at all times, when manufacturing and handling ice cream.

### Milk

Samples of milk were taken regularly throughout the year from all points of distribution i.e. from dairies, milk vehicles, shops, schools, canteens and vending machines. Details of the examinations carried out by the Public Health Laboratory are given in table form in this section of the report.

The Milk (Special Designation) (Amendment) Regulations 1965 came in operation on the 1st October, 1965. These regulations allow the sale of milk which has been "Ultra Heat Treated" but no milk under this designation has been sold in the City up to date.

### Desiccated Coconut

Two hundred and thirty six samples of pasteurised desiccated coconut were taken from a processing plant in the City. Half the samples taken were examined for Salmonellae organisms with a negative result in every case. The remainder were subjected to coliform examination and with the exception of a small number of isolated cases were reported to be satisfactory.

### Liquid Egg

Routine sampling of pasteurised liquid egg was taken during the year and examined for efficiency of heat treatment. All samples were satisfactory.

### Miscellaneous Foods

During the year cooked meats and frozen foods were sampled periodically for bacteriological examination. Generally these were satisfactory with the exception of several prepacked meals in which a slight growth of Staph. aureus persisted over several samples. Investigations were carried out and and the food handlers involved were subjected to a routine of hand washing with the use of a barrier cream which eliminated the organism.

## FOOD POISONING

There were no mass outbreaks of food poisoning. Thirteen individual cases of persons affected with food poisoning organisms were notified during the year.

Individual enquiries were made in every case, and appropiate advice given re personal hygiene.

During July/August there was an outbreak of Paratyphoid B in the Blackpool area, this being eventually traced to a particular farm where a cow was excreting the organism with its milk, and the milk not being subject to pasteurisation.

Several persons from this City who were on holiday in Blackpool were affected, and as a result of this many people were visited and specimens taken.

Four persons were proved to be positive; one of whom was admitted to hospital; the other three were mild, and recovery took place within a few days. There were no secondary cases.

## PET ANIMALS ACT 1951

There are 15 pet shops in Salford which are licensed by the City Council.

Regular inspections are carried out and close liaison is maintained with the R.S.P.C.A. Compliance with the Act has been achieved in all cases by informal action.

## ANIMAL BOARDING ESTABLISHMENTS ACT 1963

Only two premises are licensed for the boarding of dogs and cats. In one case a limited licence has been granted because of deficiencies in the premises.

## HAIRDRESSERS AND BARBERS

During the course of this year applications for registration have been received in respect of 16 premises. A condition of registration is compliance with the bye-laws, and this has been achieved in all new premises registered.

A survey of existing premises is under way, and improvements have been achieved where necessary.

Particular attention has been given to the following matters :—

1. Ventilation — In ladies hairdressers mechanical ventilation is advised because of the use of aerosol lacquers and other substances.

2. Sterilisation of equipment.

3. Washing of towels. In a few cases towels have been found which are obviously not properly washed after being used on each customer.

4. Refuse storage.

5. First aid.

In most cases compliance has been achieved informally, but a small percentage of premises are being considered for further action in the coming year.

## SHOPS ACT 1950

The health and welfare provisions of the Act having been repealed, the scope of the Act is now restricted to closing hours, Sunday trading restrictions, and hours of work of young persons.

This legislation is not popular, nor is it easy to enforce, and a great deal of tact has to be used to deal with the disputes which arise from time to time between retailers. In all cases dealt with this year compliance has been achieved by informal discussion and advice, and where necessary by Sunday Inspections and evening Inspections.

## SHOPS (EARLY CLOSING DAYS) ACT 1965

This Act has been welcomed by many people as the first sign of modernisation in the law relating to shops. Its effect is to allow shopkeepers to observe an early closing day of their own choice. In general the early closing

day in Salford seems to have been affected little by this measure, although in one or two trades changes have been made. Notably a considerable number of Ladies Hairdressing establishments are providing a service on a Wednesday afternoon, and observing a different day as early closing day (commonly Monday).

All closing orders are repealed by the Act, but exemption orders remain in force. Because of these Exemption Orders the effect of the Act is slightly different in the areas of different local authorities. For this reason a leaflet has been prepared which is available free on request to Salford shopkeepers. The following is a reproduction of this leaflet.

CITY OF SALFORD

SHOPS (EARLY CLOSING DAYS) ACT, 1965

This Act makes certain changes in the law relating to early closing days, which come into force in Salford with effect from the 5th November 1965.

In future the early closing day is to be chosen by individual shopkeepers to suit their own convenience.

Some types of shops are not bound by law to observe an early closing day, and the position of these shops is not changed except that butchers' shops are added to the list of shops which are not bound to observe an early closing day. Staff employed in such shops are, of course, still entitled to a weekly half holiday.

**Shops Exempted from Observing an Early Closing Day in Salford**

Butchers
Grocers
Bread and Confectionery Shops
Cooked Meat Shops
Greengrocers
Fishmongers
Sweets/Tobacco/Toys/Stationery/Newspapers
Cafes/Restaurants/Fish and Chips
Chemists
Intoxicating Liquor Shops
Motor Traders

Shops not shown on the above list are required to observe an early closing day, but the day may be chosen by individual shopkeepers to suit their own convenience. The day chosen must be conspicuously displayed on a notice at the customer's entrance to the shop, and the day must not normally be changed more frequently than once every 3 months.

Queries on this subject should be addressed to the Chief Public Health Inspector, Health Department, Crescent, Salford, 5.

## OFFICES, SHOPS AND RAILWAY PREMISES ACT, 1963

This is the first complete year during which the main provisions of the Act have been in force. The time available has been used to carry out inspections in as wide a variety of premises as possible, to assess the problems which inevitably arise with legislation which covers such a variety of circumstances. Experience to date suggests that in general the requirements of the Act are well suited to modern conditions.

### Registration of Premises

The registration of premises is now virtually complete. There is, of course, a continuing problem brought about by changes of occupation, changes in whether staff are employed or not, new premises opening, etc. Control of new premises is achieved by regular liaison with the Town Planning Officer. Changes in circumstances in existing premises are more difficult to control for obvious reasons, but observation by District Inspectors when visiting each district is reasonably effective.

### Provision of Information to Employers

In order to establish contact with employers in advance of the inspection programme, a circular letter was sent out to all premises immediately on receipt of form OSR.1 (Registration form). This letter contained basic information about the Act and Regulations, and invited employers to contact the enforcing authority if advice was required. An additional circular has been sent out giving details of the Abstract required to be exhibited in premises by the Information for Employees Regulations, 1965. The opportunity was taken at the same time to enclose a reminder about the obligation to notify accidents. Copies of the circulars sent out are reproduced in appendix 2 of this report.

An illustration of the value of the circulars is that in many cases the first general inspection of premises reveals that the abstract is posted, and first aid facilities are provided as a direct result of the circulars. Also the level of accident notification is higher than it would otherwise have been.

### Problems of Demarcation in Enforcement

The close liaison established with the Factory Inspectorate at both regional level and district level has been maintained. The liaison is, of course, essential to the smooth running of the Act because of the substantial number of premises which are subject to both the Factory Acts and the Offices, Shops and Railway Premises Act.

There have been several cases of diffuculty during the year which have necessitated joint visits to premises. In every case satisfactory administrative arrangements have been agreed upon. Any employer or employee who is in any doubt as to the identity of the enforcing authority, and wishes to clarify the position, should contact either the local authority or the local office of the factory inspectorate for information.

**Co-ordination Arrangements**

It is obviously desirable that various enforcing authorities should be aware of the standards and policy of enforcement being followed in various districts. To achieve this, and to facilitate uniformity of enforcement a series of meetings have been held which have been attended by both Public Health Inspectors and Factory Inspectors. Meetings in the year under review have been held under the auspices of the Ministry of Labour, Association of Public Health Inspectors and the Institute of Shops Act Administration.

**Enforcement Arrangements**

General inspections have been carried out generally on a block by block basis, with some selective visiting in special circumstances. Examples of circumstances where selective visiting has been necessary include complaints from employees and accident reports.

Where contraventions have been found the occupier or person responsible has been requested by letter to put matters right. Follow up visits have been made in every case, and in general if informal action has not produced results within six months of the general inspection, a report is made to the City Council for consideration of legal proceedings. It is indicative of the co-operation achieved so far, that in only one case this year has it been necessary to institute legal proceedings.

Contraventions of the Act were found in 85% of the premises given a general inspection this year. In the vast majority of cases, the requirements have not been a heavy burden to employers. The majority of well managed businesses have little difficulty in carrying out the requirements, and where serious difficulty has been experienced it is usually due to unsatisfactory buildings or bad management.

**Cleanliness**

Most cases of lack of cleanliness have been found in rooms other than those to which the public resort, and most commonly in little used parts of premises. Generally, re-decoration has been asked for in addition to cleaning where appropiate.

**Overcrowding**

Cases of overcrowding have again been found to be rare. No serious cases have been noted this year, but four cases of slight overcrowding were found and arrangements were made to eliminate it by re-allocation of space.

**Temperature**

It has again been found that generally deficiencies of heating are found more commonly in shops and warehouses, than in offices. A substantial number of complaints from employees were received and dealt with. Certain employers have resisted suggestions to improve heating in shops on the grounds of practicability, and after protracted correspondence agreement has

not yet been reached. One particular employer claims that his shops should be exempted under Section 3 (b) because the opening and shutting of the door renders the achievement of a reasonable temperature impracticable. These particular shops do not stock any goods which could be said to to deteriorate in warm conditions, and it is felt that Section 3 (b) does not apply here. If agreement is not reached soon consideration is to be given to legal proceedings.

### Ventilation

The majority of premises both old and modern are ventilated entirely by natural means, and this is usually found adequate subject to repairs to windows and fanlights. In the case of food premises where cooking is carried on, hairdressing salons where high humidity occurs, mechanical ventilation is usually necessary and in a number of cases improvements have been required.

### Lighting

In modern office buildings the general standard of both natural and artificial lighting has been found to be good by European standards. Levels of illumination in the range 20 to 40 lumens per square foot at desk level are commonly found.

In older type offices lower standards are frequently found, although a significiant proportion has been found to have improved the standard in the working areas. Standards on staircases, passages and stockrooms are generally poor, particularly so in the common parts of plurally occupied buildings, where owners are normally responsible. In many such passages and staircases lighting is not even provided at each change of direction.

In shop premises both old and new, the majority provide a reasonable standard in the selling areas. Occasionally very high standards are found in selling areas, in the range 50–100 lumens per square foot. In the stock rooms, staff rooms, staircases and passages, however, poor standards are often found particularly in older type premises.

### Examples of Unsatisfactory Lighting

An optician's reception room was found lighted entirely with wall lighting. The receptionist was expected to carry out clerical work with a lighting standard of only 5 lumens per square foot at desk level.

In a drawing office in a converted Victorian mansion the general lighting in the room was about 3 lumens per square foot. This was also supplemented by desk lights, but was regarded as inadequate because the poor general lighting was not sufficient for reference to filing cabinets, book cases, etc.

Water closets are frequently found without any artificial lighting particularly in the older type of premises with an external water closet. In these cases electric lighting has been required except in cases where the property has a limited life due to slum clearance proposals.

Unsatisfactory lighting has not been found to be associated with particular classes of premises, but rather to vary from place to place, with the exception that it is rarely found in new buildings.

**Recommendation to Occupiers**

Where it has been decided to require improvements in lighting, occupiers have been advised to achieve a standard not less than 20 lumens per square foot at desk level, In general, however, action has not been required unless the standard is found to be below 15 lumens per square foot at desk level, pending the making of specific regulations.

**Problems of Glare**

The most common circumstances in which glare has been found is in modern office blocks with large windows. Glare from sunlight has been found to be very acute, according to the aspect of the rooms. Occupiers have been requested to provide blinds or curtains in such cases.

The question of glare from artificial lighting is, of course, a very complex one. Even in new premises sufficient account is not always taken of the problem of glare, when arranging the layout of lighting fittings. In several such cases occupiers have been requested informally to fit diffusers to minimise the difficulty.

In only one case has an occupier been required to carry out a major lighting improvement on account of serious glare. In this case, several drawing offices were lighted almost entirely with powerful individual desk lights. The rooms were lofty and painted in dark colours and the general lighting was generally below 3 lumens per square foot at desk level. The contrast between the powerful desk lights and the poor general lighting and dark colour scheme was so great that the staff complained strongly about glare. These offices have now been provided with good general lighting with fluorescent fittings, and much less powerful desk lights are now in use for fine work.

**Sanitary Conveniences and Washing Facilities**

Little difficulty has been found with the adequacy of water closet provision, most premises being overprovided as compared with the standard laid down in the regulations. The few cases of difficulty found are in premises where the number of staff is marginally in excess of five and where separate water closet facilities or washing facilities will therefore be required.

The most common contravention found with water closets is the poor cleanliness and decoration, and lack of lighting.

A substantial proportion of shops (except food shops) are found to require a hot water supply. In a few cases hot water systems have been found used jointly by a shop or office with a flat above. This arrangement is sometimes found unsatisfactory, because the control of the system is impracticable when the tenant of the flat is not at home. The action taken is decided on the basis of whether hot water is available at the time of the inspector's visits. In special cases a series of visits have been made at varying times to prove the point.

### Drinking Water

Up to the present, few problems have been found. One isolated case concerned a ladies' hairdressers. The sole supply of water at the premises was through a flexible tube with a perforated rose at the discharge end. This appliances was designed for washing ladies' hair, and it was felt that it was not suitable as a source of drinking water. A conventional tap was required to be fitted in addition to the hair washing appliance.

### Accommodation for Clothing

Facilities for hanging and drying clothes vary greatly and range from drying rooms with central heating to improvised arrangements such as hanging a coat on a chair in front of a fire to dry. Requirements have been related to circumstances, subject to the overriding condition that some facilities must be available.

### Seating Arrangements

The few cases of unsatisfactory arrangements were in banks and at cashier's desks in supermarkets. Arrangements in such premises vary greatly and occasionally staff are found to prefer standing. Employers have been required to make suitable seats available.

### Eating Facilities (Shops only)

The standard of facilities provided varies greatly, and in some cases provision is non-existent because of lack of space. Where facilities are not available it has been required that employees have at least one hour for lunch as required by the Shops Act, 1950, when employees have to leave the premises for meals.

### Floors, Passages and Stairs

A substantial number of contraventions have been found notably absence of handrails, obstructions, poor maintenance of treads and floors, bad lighting, etc.

Openings in floors have been a problem particularly in licensed premises, and also teagle openings in warehouses.

### First Aid

This is a matter which tends to be neglected, and in the majority of cases improved facilities have been necessary. There is also a tendency to neglect the question of replenishment of first aid boxes and this is carefully reviewed at every visit.

### Safety of Machinery

In general machines are found mainly in butchers, grocers, wallpaper shops, laundrettes, warehouses and stockrooms, and in the larger type of offices where lift machinery and sometimes guillotines or printing machinery is found.

Problems dealt with during the year include food slicers, refrigerator and compressor motors, wallpaper trimmers, baling presses and hoists and and lifts.

Regulations to control hoists and lifts would be useful and also the problems associated with teagle openings. By liaison with the Factory Inspector it has been possible to secure similar standards as are enforceable under the Factory Acts. Legal powers are obviously desirable however.

**Accidents**

During the year 41 accidents have been reported on Form SOR.2 and of these 37 were found to be notifiable under Section 48. The injuries in most cases were relatively minor, typical examples being sprained backs, bruising, slight fractures, etc. In one case, however, the accident was fatal, and in another case nearly so, The following is a brief outline of these two serious accidents.

**Fatal Accident in Wholesale Shop**

A fatal accident occured when a storeman was crushed by a stack of steel conduit tubes, when the rack supporting the tubes collapsed suddenly.

The 12 foot long conduit pipes were stored almost vertically, being simply leaned on a metal rack constructed of 2" x 2" angle iron. The rack, which supported about 7 tons of pipes, collapsed suddenly due to the failure of a welded joint. Three employees were near the rack at the time of collapse and two escaped. The man killed was not able to escape because there was no passage between the rack and the wall.

A full investigation was carried out and it was found that the main causes of the accident were as follows :-

(a) The welded joints on the rack were of very poor quality.

(b) The design of the racks was faulty, insufficient bracing having been provided.

(c) There was no maximum loading limit laid down by the management for these racks.

(d) The layout of the warehouse was not in accordance with good practice because many of the passages between racks were culs-de-sac. This man may well have escaped had there been an escape route.

Subsequent to this accident all similar racks have been required to be destroyed and a properly designed storage system provided.

**Accident to Butcher**

A butcher's apprentice aged 16 years was boning out a shoulder of beef when the knife slipped and his femoral artery was almost severed. Prompt action by the butcher and the availability of excellent first aid facilities saved this boy's life.

In this case the premises were well lighted, clean, well equipped, and provided with excellent first aid facilities. The boy was under supervision and had been given training and supervision in the work, including slaughtering. In these circumstances it was felt that no statutory action was warranted.

**Attitude of Employers**

The vast majority of employers have co-operated and have carried out the requirements of the Act in response to informal requests by inspectors.

In only one case was it not possible to reach agreement, and legal proceedings were instituted in the magistrates court. A fine of £36 was imposed in the respect of lack of cleanliness, badly maintained water closet, lack of handrails on a staircase, lack of first aid facilities, and inadequate clothing accommodation.

A growing awareness of the Act is noticeable amongst employees, possibly as a result of the posting of the Abstract in so many premises.

The cold spell in the autumn produced a flow of complaints to the local authority about heating inadequacies, and there have been a few complaints about meal facilities and hot water supplies. One odd point noticed is that employees seem completely indifferent to bad lighting. Several cases where clerical work was carried on with lighting at 5 lumens per square foot at desk level were found, when the employees had not noticed any inadequacy.

**Conclusion**

The operation of the Act appears to be working smoothly in Salford and it is hoped that the complete survey will be finished within 2 years.

## TABLE A – Registrations and General Inspections

| Class of premises | Number of premises registered during the year | Total number of registered premises at end of year | Number of registered premises receiving a general inspection during the year |
|---|---|---|---|
| (1) | (2) | (3) | (4) |
| Offices | 23 | 427 | 150 |
| Retail shops | 38 | 888 | 346 |
| Wholesale shops, warehouses | 8 | 96 | 46 |
| Catering establishments open to the public, canteens | 20 | 244 | 82 |
| Fuel Storage depots | – | 14 | 1 |
| Totals | 89 | 1,669 | 625 |

## TABLE B – Number of visits of all kinds by Inspectors to Registered Premises

| 1,485 |
|---|

## TABLE C – Analysis of Persons Employed in Registered Premises by Workplace

| Class of Workplace | | No. of persons employed |
|---|---|---|
| (1) | | (2) |
| Offices | | 3,613 |
| Retail shops | | 2,779 |
| Wholesale departments, warehouses | | 1,174 |
| Catering establishments open to the public | | 1,582 |
| Canteens | | 42 |
| Fuel Storage depots | | 110 |
| | Total | 9,300 |
| | Total Males | 4,703 |
| | Total Females | 4,597 |

## TABLE D – Exemptions

Nil

## TABLE E – Prosecutions

Prosecutions instituted of which the hearing was completed in 1965

| Section of Act or title of regulation | Number of persons or companies prosecuted | Number of informations laid | Number of informations leading to a conviction |
|---|---|---|---|
| (1) | (2) | (3) | (4) |
| 4 | 2 | 1 | 1 |
| 6 | 2 | 1 | 1 |
| 9 | 2 | 1 | 1 |
| 12 | 2 | 1 | 1 |
| 16 | 2 | 1 | 1 |
| Section 24 and First Aid Order 1964 | 2 | 1 | 1 |

Number of complaints (or summary applications) made under Sec. 22 – Nil.

No. of interim order granted – Nil

## TABLE F – Inspectors

| | |
|---|---|
| No. of Inspectors appointed under section 52(1) or (5) of the Act | 2 |
| No. of other staff employed for most of their time on work in connection with the Act | 1 |

## PEST CONTROL SECTION

### RODENT CONTROL

**(a) Sewer Treatment**

The three man team once again carried out the never ending job of inspecting, baiting and recording the 3,110 manholes within the City during the year, three maintenances were carried out using Warfarin containing foranitrophenal and all manholes were baited until "no takes" were recorded.

It is of interest that our method of baiting sewers i.e. "bag baiting" has been recognised by the Ministry of Agriculture, Fisheries and Food. In July a "technical circular" was sent by the Infestations Control Laboratory, Tulworth, Surrey to all Local Authorities in the country recommending our method and acknowledging the fact that the staff of the City of Salford devised the method.

The problem of baiting the sewers effectively and keeping accurate records of the "takes" and "estimated number of rats killed" caused the rodent control section a lot of trouble as the method previously in use was open to all sorts of abuse and if not carried out correctly was a waste of time, materials and money.

After months of experiments with all sorts of contraptions such as portable trays lowered on piano wires, it was found that muslin bags suspended into the manholes could be the answer. After further weeks of trials and observations on the habits of the rats and their method of attacking the bags it was found that the bags shaped like a cylinder hung by sizal string into the manholes with the last two feet made up of wire so that the rats could not gnaw through the string and take the bags, was the best method.

Using this method accurate records can be kept and any movement of rat population in the sewers can be pinpointed and dealt with immediately.

The following table gives a summary of the years work.

| Section of System treated | Total No. of manholes in the System | No. of manholes treated | | | No. of manholes showing takes | | |
|---|---|---|---|---|---|---|---|
| | | 41st Main-tenance | 42nd Main-tenance | 43rd Main-tenance | 41st Main-tenance | 42nd Main-tenance | 43rd Main-tenance |
| Salford 1/13 | 907 | 880 | 856 | 873 | 73 | 63 | 102 |
| Broughton 1/11 | 741 | 720 | 713 | 721 | 50 | 20 | 27 |
| Pendleton 1/17 | 1,462 | 1,422 | 1,427 | 1,417 | 45 | 55 | 33 |
| TOTAL | 3,110 | 3,022 | 2,996 | 3,011 | 168 | 138 | 162 |

| Section of System treated | Weight of Bait taken in ozs. | | |
|---|---|---|---|
| | 41st Main-tenance | 42nd Main-tenance | 43rd Main-tenance |
| Salford 1/13 | 260 | 168 | 264 |
| Broughton 1/11 | 150 | 53 | 77 |
| Pendleton 1/17 | 127 | 154 | 99 |
| TOTAL | 537 | 375 | 440 |

41st Maintenance 13. 11. 64. to 25. 3. 65.
42nd Maintenance 26. 3. 65. to 29. 7. 65
43rd Maintenance 30. 7. 65 to 16. 11. 65.

### (b) Surface Investigations and Treatment

During the year 1,151 complaints were received at the Health Department. On investigation only 155 were found to be infested with rats and 681 infested with mice.

The treatment for rats is carried out free of charge in dwelling houses but occupiers of business premises are charged 15/-d. per house inclusive of materials.

No such free service is given to owners or occupiers of dwelling houses in the case of mice infestations, except in cases of hardship. The operator calls, advises and sells pre-packed boxes of Warfarin at 9d. per box. These boxes are also available at the Health Department. Occupiers of business premises are charged 15/-d. per hour, inclusive of materials.

Preliminary notices were served on 29 owners where drains were found to be defective and allowing rats to escape, and in all cases the drains were repaired or old drains sealed off.

The co-operation between landlords, contractors and staff can be clearly seen as not one Statutory Notice had to be served. As soon as tests reveal defective drains the landlord is contacted by telephone and within 24 hours the contractor telephones the Pest Control Office and arrangements are made for the foreman operator to supervise the tracing of the rat runs to their source. Landlords appreciate this close co-operation as it saves them time and money on each job.

## FERRAL PIGEONS CONTROL

The problem of nuisance from wild pigeons in Salford is growing and causing some concern. A week does not go by without several complaints by angry people of damage and nuisance caused by the pigeons.

These wild pigeons are attracted to Salford by people feeding the birds in the streets, yards and passages. By regular feeding the birds establish roosting and nesting sites quite close to this source of food and flocks up to 50 or more can be seen on window sills and roofs of properties in the area. What the public who feed these pigeons do not realise is the amount of damage caused by the birds. Not only do they deface property and foul the surface of streets, yards and passages with their droppings making the surface slippery and treacherous in wet weather and a hazard to elderly people: they attack the fabric of buildings and dwelling houses by pecking away at window sills and roofs and ultimately dislodging slates to gain access to the roof space to roost and nest.

Once they have established themselves in the roof space of a terrace of property the problem becomes serious. They can keep people awake night after night by their cooing and fluttering about and in some cases terrorising young children and babies with the noise. But even worse than disturbing the peace of the home they cause the home to be invaded by either rats, mice, insects or the combination of these.

With abundant food supply left for the pigeons, rats and mice quickly find the residue and establish themselves in the area, start breeding and in a short period the area is infested.

Insects of all kinds are also attracted, some that are carried on the pigeons themselves and some that are enticed into the nesting and roosting places by a rich supply of vegetable and animal materials which can support a large insect population for a long period.

From the Public Health aspect and from the point of view of the clean and house-proud tenant or owner-occupier it is very disturbing for the home to be invaded with insects such as larder beetles, spider beetles, carpet beetles, moths, common fly and numerous other insects, not through the fault of the occupier but due to a person or persons in the street feeding and attracting the pigeons.

The people who feed these birds generally live in tenanted dwelling houses and do not have to pay for repairs and damage caused by the pigeons and could not care less about their neighbours who may have struggled to buy and keep in good repair their homes and can ill afford to have extra burden of repair bills on their hands.

These are the hard facts and the Public Health Inspectors has a duty to the community at large. In Autumn an anti-pigeon campaign commenced with articles in the local papers requesting offenders to stop feeding and pointing out the damage caused by the birds. This was followed up with traps sited in one section of the City.

Bob wire traps are made of light timber, covered with 1" mesh wire netting, with approximately one half of the top covered with hardboard to provide shelter for the pigeons during inclement weather. Each trap measures 6' × 3' × 1' and is designed to be mobile and fit on flat-roofed air raid shelters in backyards of dwelling houses. The trapped birds are kept constantly supplied with food and water and the cages emptied once or twice a week.

Unfortunately winter came upon us before we were able to assess the efficiency of the traps, but during this short period of 5 weeks 84 pigeons were caught and humanely destroyed. It is hoped that next years annual report will show a dramatic reduction in the pigeon population.

## DISINFESTATION SERVICE

The two full time operators covered 8,800 miles in the light van during the year. A nominal charge of 7/-d. per room is made to all occupants of dwelling houses who require the service irrespective of the type of infestation found. The money is paid to the operator who issues a receipt. In cases of hardship such as families on National Assistance and Old Age Pensioners a free service is given. Business premises are treated on the basis of "time and materials". Corporation buildings and Offices and Hospitals in the City are also covered by this service.

The following table shows the volume of work carried out during the year.

| Type of Infestation | 1964 | 1965 |
|---|---|---|
| Blow Flies | – | 1 |
| Bed bugs | 185 | 190 |
| Cockroaches | 404 | 492 |
| Woodweavil | 3 | 1 |
| Earwigs | 4 | 1 |
| Flies | 23 | 28 |
| Golden Spider Beetle | 7 | 17 |
| Mites | – | 2 |
| Silverfish | 2 | 1 |
| Wasps | 4 | 21 |
| Fleas | 12 | 12 |
| Larder Beetles | 83 | 50 |
| Ants | 1 | 6 |
| Moths | – | 1 |
| Steam Flies | 1 | – |
| Woodworm | – | 2 |
| Lice | 5 | 3 |
| Midgies | – | 5 |
| | 734 | 833 |

In addition to the 833 treatments for specific infestations, 1,168 slum clearance dwelling houses and furniture were sprayed with insecticides prior to removal of the families to new homes, an increase of 60 on 1964. Also fly proofings as a precautionary measure was carried out at 25 school canteens and 24 visits were made to hospitals to treat for cockroaches.

1,551 tins of beetle powder were sold and 91 tins issued to Corporation tenants at the inquiry counter so that tenants could carry out their own treatment.

## DISINFECTION SERVICE

Bedding and clothing from houses where there are infectious cases, bedding from houses in slum clearance areas in Salford and from neighbouring local authorities, bedding from verminous dwelling houses and hospitals, clothing for forwarding to people abroad, and rags for export are steam disinfected at the station.

Books, furs, better goods etc., which cannot be treated by steam owing to excessive damage which would arise are sprayed with Formaldehyde.

The following table shows the volume of work carried out:–

| | Beds | Beds or bags containing bedding or clothing |
|---|---|---|
| Infected bedding and clothing | 86 | 128 |
| Verminous bedding and clothing | 6 | 10 |
| Clothing of patients admitted to Ladywell Hospital | – | 114 |
| Beds and bedding from Ladywell Hospital | 204 | 57 |
| Salford Royal Hospital | 12 | 19 |
| Hope Hospital | 15 | 79 |
| Eccles & Patricroft Hospital | 3 | 153 |
| Swinton Health Department | 4 | – |
| Stretford Health Department | 3 | 3 |
| Urmston Health Department | 3 | 4 |
| Port Health Authority | 2 | 2 |
| Clothing for forwarding to countries abroad | – | 2 |

| | | |
|---|---|---|
| Blankets from Ambulance Services – | Salford | 165 |
| | Urmston | 50 |
| | Stretford | 47 |
| | Eccles | 18 |

Sterilising apparatus and dressing drums from Ladywell Hospital: 1,885

Rags for export: 28 Bales

In addition to the above steam disinfection the following disinfections were carried out by spraying with formaldehyde:

| | | |
|---|---|---|
| Ladywell Hospital | 548 Beds | |
| Salford Royal Hospital | 18 Beds | 22 Cubicles |
| Ambulances | 8 | |
| Ships' Cabins | 3 | |
| Hospital Library Books | 429 | |
| Dwelling Houses | 24 | |

16 demonstrations for student nurses were also arranged.

## PRESCRIBED PARTICULARS ON THE ADMINISTRATION OF THE FACTORIES ACT 1961

**Part I of the Act**

1. INSPECTIONS for purposes of provisions as to health

| Premises (1) | Number on Register (2) | Number of Inspections (3) | Number of Written notices (4) | Number of Occupiers prosecuted (5) |
|---|---|---|---|---|
| (i) Factories in which Sections 1, 2, 3, 4 and 6 are to be enforced by Local Authorities | 9 | 2 | – | – |
| (ii) Factories not included in (i) in which Section 7 is enforced by the Local Authority | 787 | 242 | 49 | – |
| (iii) Other premises in which Section 7 is enforced by the Local Authority (excluding out-workers' premises) | 31 | 31 | – | – |
| TOTAL | 827 | 275 | 49 | – |

2. Cases in which DEFECTS were found

| Particulars (1) | Number of cases in which defects were found: Found (2) | Remedied (3) | Referred To H.M. Inspector (4) | Referred By H.M. Inspector (5) | Number of cases in which prosecutions were instituted (6) |
|---|---|---|---|---|---|
| Want of cleanliness (S.1) | – | – | – | – | – |
| Overcrowding (S.2) | – | – | – | – | – |
| Unreasonable temperature (S.3) | – | – | – | – | – |
| Inadequate ventilation (S.4) | – | – | – | – | – |
| Ineffective drainage of floors (S.6) | – | – | – | – | – |
| Sanitary Conveniences (S.7) | | | | | |
| (a) Insufficient | – | – | – | – | – |
| (b) Unsuitable or defective | 49 | 38 | – | 12 | – |
| (c) Not separate for sexes | – | – | – | – | – |
| Other offences against the Act (not including offences relating to Out-workers) | 4 | – | 4 | – | – |
| TOTAL | 53 | 38 | 4 | 12 | – |

**Part VIII of the Act**

OUTWORK (Sections 133 and 134)

| Nature of Work | Section 133 | | | Section 134 | | |
|---|---|---|---|---|---|---|
| | No. of out-workers in August, list required by Section 133 (1) (c) | No. of cases of default in sending lists to the Council | No. of prosecutions for failure to supply lists | No. of instances of work in unwhole-some premises | Notices served | Prose-cutions |
| (1) | (2) | (3) | (4) | (5) | (6) | (7) |
| Wearing apparel | | | | | | |
| Making, etc. | 79 | – | – | – | – | – |
| Cleaning & Washing | – | – | – | – | – | – |
| Household Linen | 6 | – | – | – | – | – |
| Paper Bags | – | – | – | – | – | – |
| The making of boxes or other receptacles or parts thereof made wholly or partially of paper | 3 | – | – | – | – | – |
| Stuffed toys | 2 | – | – | – | – | – |
| TOTAL | 90 | – | – | – | – | – |

## STATISTICS

### LIST OF SAMPLES TAKEN

| | |
|---|---|
| Food and Drugs (other than Milk) | 389 |
| Milk for Phosphatase Test | 175 |
| Milk for Methylene Blue Test | 194 |
| Milk for Turbidity Test | 100 |
| Milk for Fats and Solids not fats etc. | 317 |
| Ice Cream | 57 |
| Fertilisers and Feeding Stuffs Act Samples | 6 |
| Pharmacy and Poisons Act Samples | 2 |
| Water Supply Samples | 11 |
| Swimming Bath Water Samples | 385 |
| Miscellaneous Samples for Bacteriological Examination (including Desiccated Coconut, Cooked Meats, etc.) | 345 |
| TOTAL | 1,981 |

## RESULTS OF MILK SAMPLES

| Test | Milk | No. Tested | Pass | Fail | % Fail |
|---|---|---|---|---|---|
| Methylene Blue | Pasteurised | 175 | 169 | 6 | 3.4 |
| ,, | Untreated | 19 | 15 | 4 | 21 |
| Phosphatase | Pasteurised | 175 | 175 | – | – |
| Turbidity | Sterilised | 100 | 100 | – | – |

## RESULTS OF ICE CREAM SAMPLES

| No. of Samples | Grades |
|---|---|
| 42 | 1 |
| 10 | 2 |
| 1 | 3 |
| 4 | 4 |

## UNSOUND FOOD CONDEMNED

The following table shows a list of goods surrendered for destruction during the year.

| | |
|---|---|
| Meat | 11,219 lbs |
| Fruit | 788 ,, |
| Vegetables | 161 ,, |
| Soup | 12 ,, |
| Creamed Rice | 2 ,, |
| Cream and Evaporated Milk | 2 ,, |
| Fish | 3 ,, |
| Pastry Fat | 224 ,, |
| Dripping | 28 ,, |
| Spaghetti | 1 ,, |
| Sago | 1 ,, |
| Jam | 18 ,, |
| Tomato Puree | 6,776 ,, |
| TOTAL | 19,235 ,, |

## NATURE OF INSPECTIONS

| | |
|---|---|
| Sanitary Defects | 13,079 |
| Houses in Multiple Occupation | 631 |
| Offices, Shops and Railway Premises Act | 2,511 |
| Shops Act | 146 |
| Housing Act – Clearance Areas | 4,497 |
| Improvement Grant | 1,782 |
| Housing Applications | 707 |
| Factories | 242 |
| Food Shops | 1,249 |
| Food Stalls and Vehicles | 201 |
| Dairies | 91 |
| Food Preparing Premises | 174 |
| Restaurants and Snack Bars | 178 |

| | |
|---|---|
| Canteens (Factory and School) | 46 |
| Unsound Food | 399 |
| Food Samples | 98 |
| Milk Samples | 158 |
| Ice Cream | 63 |
| Fertiliser and Feeding Stuffs | 3 |
| Butchers Shops | 676 |
| Infectious Diseases | 121 |
| Food Poisoning | 52 |
| Swimming Baths and Drinking Water | 301 |
| Pharmacy and Poisons | 32 |
| Slaughterhouse | 825 |
| Hen Slaughterhouse | 38 |
| Cattle Sidings | 5 |
| Public Houses | 162 |
| Hairdressers | 115 |
| Pet Shops | 32 |
| Animal Boarding Establishments | 24 |
| Places of Entertainment | 78 |
| Noise Nuisance | 47 |
| Vehicle Exhaust | 6 |
| Pest Act | 256 |
| Rodent Control | 951 |
| Pigeons | 93 |
| Schools | 46 |
| Caravans | 46 |
| Smoke Control | 9,045 |
| Miscellaneous | 448 |
| | 39,654 |
| Calls – No Admittance | 3,252 |
| Letters | 2,501 |

## COMPLAINTS AND NOTICES

| | |
|---|---|
| Complaints received | 7,376 |
| Statutory Notices issued | 3,190 |
| Statutory Notices abated | 1,714 |
| Intimation Notices issued | 853 |
| Intimation Notices abated | 457 |

# CITY LABORATORY

The City Laboratory provides an analytical service for the City of Salford and also for the neighbouring authorities of Eccles, Stretford, Sale, Urmston and Worsley. For sampling purposes the six authorities co-operate closely and participate in schemes for the integrated routine sampling of both foods and drugs.

The total number of analyses and tests from all sources was 3,805 and may be classified as follows :–

| | City of Salford | Borough of Eccles | Borough of Stretford | Borough of Sale | Urban District of Urmston | Urban District of Worsley |
|---|---|---|---|---|---|---|
| Food and Drugs Act Samples | 630 | 174 | 152 | 101 | 182 | 65 |
| Pasteurised Liquid Egg | 70 | – | – | – | – | – |
| Fertilisers & Feeding Stuffs | 6 | – | – | – | – | – |
| Miscellaneous Samples | | | | | | |
| Swimming bath waters | 378 | 28 | 3 | – | 10 | 1 |
| Contract Samples | 164 | – | – | – | – | – |
| Pharmacy & Poisons Act Samples | 2 | – | – | – | – | – |
| Others | 25 | – | – | 1 | 5 | 3 |
| Atmospheric Pollution Tests | 1,805 | – | – | – | – | – |
| | 3,080 | 202 | 155 | 102 | 197 | 69 |

Total = 3,805

In respect of the work carried out for the additional five authorities mentioned above, fees of £2,322. 16. 0. were received by Salford Corporation.

**New Legislation, etc.**

During 1965, the following food and drug regulations were made :–

The Eggs (Marking and Storage) Regulations, 1965
The Milk (Special Designation) (Amendment) Regulations, 1965
The Milk (Great Britain) Order, 1965
The Therapeutic Substances (Supply of substances for Analysis) Amendment Regulations, 1965
The Dried Milk Regulations, 1965
The Cheese Regulations, 1965.

Of these, the Cheese Regulations are probably the most important from a Public Analyst's point of view. They are completely new and are the first regulations introduced which deal comprehensively with cheese.

In addition to the above statutory regulations, proposals for regulations were introduced by the Ministry on no less than twelve different topics : many

of these were introduced as a result of Food Standards Committee Reports. This follows the usual procedure established in recent years of firstly the publication of a Report by the Food Standards Committee, followed by proposals for regulations, based on the report and circulated to all interested parties for comment, and finally the introduction of statutory regulations.

One very noticeable feature of all new or proposed legislation is the prominence given to labelling requirements to ensure that the purchaser is made fully aware of what is being supplied, not only for pre-packed articles but also for commodities sold loose and those sold from vending machines.

The Food Standards Committee was appointed in 1947 to advise the Ministers of Food and Health as to the provision to be made concerning the composition and labelling of foods. In recent years the Committee has been very active and in 1965 published reports on Fish and Meat Pastes and on Flavouring Agents. The former reviews existing orders for fish pastes and meat pastes and makes recommendations on composition and labelling. Flavouring agents are used widely in various food industries and most of them are artificial and made with synthetic materials. Some 1,500 substances were submitted for the Committee's consideration and of these about 1,000 were synthetic. These substances have in most cases been in use for many years and no apparent ill effects from them have been demonstrated. However, this cannot in itself be taken as an absolute indication of their safety and there should also be adequate toxicological data before they can be proved to be harmless. Unfortunately very little toxicological data is available and it is not at present possible to compile a list of harmless flavours. Therefore, it has been recommended by the Food Standards Committee that as a transitional stage, a list of 16 prohibited flavours should be introduced and eventually regulations should be made based on a list of permitted flavouring agents.

**Food and Drug Samples**

The total number of food and drug samples examined during the year from all sources was 1,304, This total is approximately the same as that for last year and represents an overall sampling rate from all six authorities of 3.3 samples per 1,000 population per year. The individual rates for the different authorities are given in Table 1.

TABLE 1

Sampling Rates 1965

| Authority | No. of samples per 1,000 population per year |
|---|---|
| County Borough of Salford | 4.13 |
| Borough of Eccles | 4.05 |
| Borough of Stretford | 2.50 |
| Borough of Sale | 1.91 |
| Urban District of Urmston | 4.22 |
| Urban District of Worsley | 1.51 |

Foodstuffs may be examined in the laboratory for a variety of reasons.

Firstly, if the food is pre-packed, as so many are these days, the label will be given a thorough scrutiny to ensure that all the provisions of the Labelling of Food Order and other regulations are fully complied with and that the label is in no way misleading to the purchaser. Checks are also made on advertisements to see that these too comply with the necessary regulations and are not misleading.

Secondly, the food may be analysed to determine its composition. There are standards controlling the composition of most foodstuffs. This may be a legal standard; one recommended by the Ministry; one agreed on by a Code of Practice between an appropriate trade organisation and local authorities; or a standard based on case law.

Thirdly, the food will probably be examined for the presence of food additives. These are present in many foods and may have been added for nutritional reasons, vitamins A and D to margarine and vitamins and minerals to flour for example; or they may have been added for some technological reason, for example the addition of synthetic colouring matter to improve the appeal of a food to the consumer, or the addition of preservatives to prevent deterioration of a food. The amount of these additives in foods are in many cases strictly controlled by statutory regulation.

Fourthly, the presence of food contaminants must be sought. These may be traces of toxic metals which have found their way into food, or they may be traces of such things as antibiotics in milk from cows which have been treated for mastitis, or residues of pesticides still remaining in a foodstuff after crop treatment. Again, for many of these contaminants the maximum amount allowed in a food is strictly controlled by regulation.

Finally, the sample may be a foodstuff which has been purchased by a private individual and found to be irregular in some way. Most of these "complaint" samples are foods containing foreign bodies and one of the aims of examining this type of sample is to try to establish scientifically whether the food became contaminated before or after purchase.

As regards drug sampling, the co-operation of the six authorities results in many types of drugs being analysed, ranging from the simple preparations such as tincture of iodine to the more complex drugs such as antibiotics, antidepressants and hypnotics. The standards for many drugs are laid down in the British Pharmacopoeia and the British Pharmaceutical Codex, new editions of which are introduced every five years. Normally an addendum is introduced during the five years between publications to bring them up to date, but, due to the rapid rate at which new drugs and preparations are being brought out, no less than two addenda have already been published in the three years since the last edition of the British Pharmacopoeia.

Most of the samples submitted for analysis are purchased by the Sampling Officer in the normal manner, just as a private purchaser would do; these are known as informal samples. Some samples are, however, taken formally by the procedure set out in the Food and Drugs Act, i.e. the sample is divided into three parts, one is given to the vendor, one is submitted to the Public Analyst and the third part is retained by the Sampling Officer for future analysis by the Government Chemist should the need arise.

The work done for the City of Salford may be divided into four sections – Food and Drugs, Fertilisers and Feeding Stuffs, Miscellaneous Samples, Air Pollution. Details are given in the following pages.

## FOOD AND DRUGS

Table 2 shows the number of samples examined under the Food and Drugs Act, 1955 and the irregular samples in each category.

TABLE 2

Samples examined under the Food and Drugs Act

| Samples | Number examined | Number adulterated or irregular |
|---|---|---|
| Baby Foods | 33 | 14 |
| Bread | 7 | 5 |
| Butter | 5 | Nil |
| Cereals and cereal products | 8 | Nil |
| Cheese and cheese products | 3 | Nil |
| Chocolate confectionery | 5 | Nil |
| Coffee and coffee products | 6 | Nil |
| Drugs | 24 | 5 |
| Fat (other than butter or margarine) | 2 | Nil |
| Fish products – canned | 9 | Nil |
| Flour Confectionery – other than bread | 10 | 2 |
| Fruit – canned | 3 | 1 |
| Fruit – dried | 6 | Nil |
| Fruit – fresh | 13 | Nil |
| Fruit – crystallised | 3 | Nil |
| Fruit – juice | 1 | Nil |
| Ice cream | 5 | Nil |
| Margarine | 5 | Nil |
| Meat products – canned | 29 | 7 |
| Meat products – pies | 6 | 5 |
| Meat products – sausages | 4 | Nil |
| Meat products – others | 8 | 3 |
| Milk – taken for compositional analysis | | |
| Ordinary | 249 | Nil |
| Channel Islands | 53 | Nil |
| Milk – evaporated | 11 | 1 |
| Milk – others | 15 | 9 |
| Milk – products (cream, etc.) | 9 | Nil |
| Pickles | 2 | Nil |
| Preserves | 11 | 1 |
| Puddings | 4 | Nil |
| Sauces | 9 | Nil |
| Soft Drinks | 13 | Nil |
| Soups | 2 | 1 |
| Spices, condiments and herbs | 14 | Nil |
| Spirits | 3 | Nil |
| Sugar confectionery | 2 | 1 |
| Table Jellies, deserts | 8 | Nil |
| Vegetable products – canned | 11 | 3 |
| Vegetable products – Dried | 6 | 1 |
| Vegetable products – fresh | 13 | Nil |
| | 630 | 59 |

## Milk

Standards of quality for ordinary milk are fixed by the Sale of Milk Regulations, 1939. These are not absolute standards but if a milk falls below 3.0 per cent fat or 8.5 per cent non-fatty solids it is presumed, until the contrary is proved, that the milk is not genuine by reason of the abstraction of fat or non-fatty solids or the addition of water. For Channel Islands milk there is an absolute minimum standard of 4.0 per cent fat.

Following the policy adopted in recent years, the number of milk samples was again reduced somewhat and of a total of 302 milks examined for compositional quality, not one was unsatisfactory. There were, however, several complaints about supplies of milk which was sour on delivery. The complaints were found to be quite justified as the milks had developed sufficient acidity to render them quite unpalatable.

The average composition of the milks analysed is given in Table 3, the corresponding figures for the previous five year being given for comparison.

TABLE 3

Average Composition of Milks

| | 1960 | 1961 | 1962 | 1963 | 1964 | 1965 | Minimum Standard |
|---|---|---|---|---|---|---|---|
| All Milk (Other than Channel Islands) | | | | | | | |
| Fat % | 3.62 | 3.61 | 3.57 | 3.58 | 3.55 | 3.56 | 3.0 |
| Non-Fatty Solids % | 8.68 | 8.65 | 8.68 | 8.72 | 8.82 | 8.77 | 8.5 |
| Total Solids % | 12.30 | 12.26 | 12.25 | 12.30 | 12.37 | 12.33 | |
| Channel Islands Milk | | | | | | | |
| Fat % | 4.63 | 4.86 | 4.67 | 4.66 | 4.82 | 4.67 | 4.0 |
| Non-Fatty Solids % | 8.92 | 9.14 | 9.21 | 9.20 | 9.40 | 9.26 | 8.5 |
| Total Solids % | 13.55 | 14.00 | 13.88 | 13.86 | 14.22 | 13.93 | |

## Unsatisfactory Samples

The total number of irregular food and drug samples examined during 1965 was 59 and of these 31 were 'complaints'. These figures are very similar to the previous year when the number of irregular 'complaint' samples was also about half of the total. Table 4 shows the numbers and percentages of irregular samples in the different categories.

## TABLE 4

### Classification of Irregular Salford Samples

| | Number of Samples | | Number irregular | | Percentage irregular | |
|---|---|---|---|---|---|---|
| | 1964 | 1965 | 1964 | 1965 | 1964 | 1965 |
| Total Food and Drug Samples including 'complaints' | 791 | 630 | 62 | 59 | 7.85 | 9.35 |
| Milks | 476 | 302 | 2 | – | 0.42 | – |
| Food and Drugs (other than milks) including 'complaints' | 315 | 328 | 60 | 59 | 19.05 | 18.0 |
| Food and drugs excluding milks and excluding 'complaints' | 269 | 279 | 27 | 28 | 10.0 | 10.0 |
| Food and Drugs including milks but excluding 'complaints' | 745 | 581 | 29 | 28 | 3.9 | 4.8 |
| 'Complaint' samples | 46 | 49 | 33 | 31 | 71.7 | 63.3 |

Details of the unsatisfactory foods and drugs (other than milks examined for compositional quality) are given in Table 5. In this table numbers prefixed by the letter 'A' are formal samples, those by letter 'B' are informal ones and those suffixed by letter 'C' are 'complaint' samples.

## TABLE 5

### Unsatisfactory Food and Drug Samples (other than Milk)

| Serial Number | Description | Nature of adulteration or irregularity | Remarks |
|---|---|---|---|
| B2822/C | Pork Luncheon Meat | Dark grey discoloration due to excessive amounts of tin and iron | Manufacturer notified. Further samples inspected. |
| B2835/C | Corned Beef | The can was badly corroded along the seams and in many places was incrusted with iron salts. Mould also present. | Packers notified. also stock investigated |
| B2841/C | Sterilised Milk | The foreign material present was thought to be small globules of dirty mineral oil or grease | Dairy representative interviewed. Premises inspected. |
| B2867 | Full Cream Evaporated Milk | The "Equivalent Pints" in this sample was slightly less than stated on the can | Further sample taken and found to be satisfactory. |

| Serial Number | Description | Nature of adulteration or irregularity | Remarks |
|---|---|---|---|
| B2909/C | Strained Beef Broth | The mould growth was thought to have been due to a blow on the cap having caused leakage of the vacuum seal. | Manufacturer notified and cautioned. Representative interviewed. |
| B2940 | Vegetable Salad (Canned) | The amount of tin present was twice the recommended maximum. | Stock withdrawn from sale. Further samples also unsatisfactory so stock destroyed. |
| B2938 | Baby Food.Strained Bananas with Pineapple | Claimed Vitamin C, but the amount present was negligible. | Manufacturer given severe warning. |
| B2941 | Baby Food, Rice Cereal | Vitamin declared but the amount was not given | Manufacturer informed. |
| B2864 | Victoria Plums | Minor technical labelling infringement | Packers notified. Label to be amended. |
| B2973<br>B2974 | Vegetable Salad Canned | Excessive amounts of tin present | Stock surrendered for destruction. |
| B2980/C | Meat Pasty | Contained a fly | Baker cautioned. Premises inspected. |
| B2986<br>B3077 | Baked beans with Baconburgers | Excessive amounts of tin present | Stock withdrawn from sale. Manufacturers to investigate all other stocks of similar articles. |
| B2995 | Mixed Dried Fruit | Contents disagreed with list of ingredients | Further sample satisfactory. |
| B3005/C | Part of large white loaf | Foreign object embedded in the bread was found to be the head of a metal stud or rivet | Legal proceedings taken. Fine of £50 imposed. |
| B3004/C | Large white loaf | Five slices contaminated with dirt | From same bakery as B3005/C. |
| B3018/C | Bacon Rind | Green discolouration was due to an excess quantity of copper. 180 ppm as compared with the recommended limit of 20 ppm. | Stock withdrawn from sale. |
| B3015/C | Piece of Potato | Insect present which was found to be the larva of a beetle | Warning letter sent to proprietors. Bakehouse inspected. |
| B3028/C | Dirty Milk Bottle | Foreign material present consisted of mould growth and particles of grit, some algal matter and an occasional textile fibre | Warning letter sent to dairy. |

| Serial Number | Description | Nature of Adulteration or Irregularity | Remarks |
|---|---|---|---|
| B3038 | Emulsion of Liquid Paraffin with Phenolphthalein | Phenolphthalein much lower than B.P.C. specified limit | Manufacturer notified further sample satisfactory. |
| B3042 | Baby Mixture | The declaration of active ingredients not strictly in accordance with the form required by the Pharmacy and Medicines Act | Manufacturer notified. |
| B3044<br>B3045<br>B3046 | Bone & Vegetables<br>Chocolate Cereal<br>Vegetable and Chicken | There was no statement on the label of any of the samples of the quantities of vitamins and minerals present in the food but these were claimed in a magazine advertisement. | Packers notified.<br>Faulty advertisement immediately withdrawn. |
| B3085/C | Oxtail Soup | Insect-like object present. This was found to be a piece of rolled paper | Canners representative interviewed. |
| B3086/C | Pasties | On the crust of one pasty were two small patches of mould. Confirmed as a penicillium growth | Warning letter sent to proprietor. Premises inspected. |
| B3098/C | Meat Sandwich | Analysis showed that considerable deterioration had taken place in the meat | Vendor interviewed, premises inspected. Trouble due to break-down in refrigeration plant. |
| B3148/C | Catering mix | Insects present identified as grain weevils | Further stock checked and found to be satisfactory. |
| B3149/C<br>B3150/C<br>B3151/C<br>B3152/C<br>B3153/C<br>B3154/C<br>B3155/C | Milks – taken from different premises | Acidities sufficiently high to render the milks unpalatable | Dairy informed and representative interviewed. |
| B3167 | Seidlitz Powders B.P.C. | One powder was slightly outside B.P.C. weight limit | Repeat sample satisfactory |
| B3171 | Emulsion of liquid paraffin and magnesium hydroxide B.P.C. | Supplied in wrong type of bottle and labelling insufficient | Pharmacist notified. |

| Serial Number | Description | Nature of Adulteration or Irregularity | Remarks |
|---|---|---|---|
| B3181/C | Chocolate Swiss Roll | Mould growth present | Warning letter sent to baker. |
| B3182/C | Sliced White Loaf | Each slice badly contaminated with mould | Warning letter sent and bakery inspected. |
| B3183/C | Corned beef | Can showed corrosion. Bluish spots on meat due to iron salts | Manufacturers notified. Representative interviewed. |
| B3214/C | Cooked Lamb – discoloured | Bright pink colour due to chromogenic bacteria | Complainant notified. No further action. |
| B3287/C<br>B3288/C | Corned Beef | Cans rusted and in generally bad condition; contents putrid; toxic metals present in excessive amounts | Warning letter sent to manufacturers. |
| B3296/C | Sweet | Two large rust particles present | Representative interviewed. |
| B3300/C | Pork Pie | Affected by mould growth | Warning letter sent to baker. |
| B2872<br>B2873<br>A1310<br>A1311<br>A1312 | Baby Foods | The advertising claims about the nutritional value of these baby foods were thought to be misleading | Further samples A1316-8 taken. |
| B3308/C | Small white loaf | Wooden splinter embedded in bread | Warning letter sent to bakery. Premises inspected. |
| B3362 | Cough Linctus | Labelling irregularity Declaration of quantitative particulars not stictly in accordance with requirements | Manufacturers notified. |
| B3415 | Mixed Vegetables | Composition not in accordance with Code of Practice for canned vegetables | Further sample satisfactory. |
| B3431/C | Part of large white sliced loaf | Some grey fibrous matter identified as cotton was embedded in one slice of the loaf | Bakers notified. |
| B3454 | Mincemeat | Sample deficient in dried fruit and peel content to the extent of 20% | Manufacturers notified. Further stock checked and found to be satisfactory. |

| Serial Number | Description | Nature of Adulteration or Irregularity | Remarks |
|---|---|---|---|
| A1316 | Strained Beef and Egg Noodles with Vegetables | The advertising clauses about the nutritional value of these baby foods were thought to be misleading | Legal proceedings taken. Case dismissed 200 guineas costs awarded against Salford Corporation. |
| A1317 | Strained Beef and Egg Noodles with Vegetables | | |
| A1318 | Junior Dinner Beef and Egg Noodles with Vegetables | | |

**Pasteurised Liquid Eggs**

The Liquid Egg (Pasteurisation) Regulations 1963, are enforceable by Food and Drug Authorities and require the pasteurisation of liquid egg to be used in food intended for sale for human consumption, other than egg broken out on the food manufacturer's premises, kept at a temperature not more than 50° F. and used within twenty-four hours.

The regulations prescribe that pasteurisation shall be carried out by retaining the liquid egg at a temperature of 148° F (64.4° C) for at least 2½ minutes and immediately cooling to a temperature below 38° F (3.3° C). For testing whether or not these conditions have been used, a method similar to the phosphatase test for pasteurised milk is given but depending on a different enzyme, namely alpha – amylase.

During 1965, 70 liquid egg samples were taken and submitted to the alpha-amylase test. All were satisfactory.

## FERTILISERS AND FEEDING STUFFS ACT

The use of feeding stuffs for cattle and poultry in an urban area is very limited and consequently, in the past, the only samples taken were from manufacturer's premises in Salford. Due to a recent fire, however, the only mill in this area producing these was destroyed and has since been rebuilt elsewhere. During 1965, therefore, no feeding stuffs were analysed.

The results of the six fertilisers examined are given below :–

| Samples | Results | Action taken |
|---|---|---|
| Growmore fertiliser | Satisfactory | |
| Liquinure | ,, | |
| Sangral | ,, | |
| Growmore fertiliser | ,, | |
| Super-phosphate | Phosphoric acid slightly outside limits of variation. | Further sample taken and found to be satisfactory. |

## MISCELLANEOUS SAMPLES

### Swimming Bath Water

Various techniques are in use for the chlorination treatment of swimming bath waters but the one generally recognised as the most efficient way of maintaining the water in a satisfactory bacteriological condition is known as the breakpoint method of chlorination. This method is designed to ensure as far as possible that the chlorine in the water is present in the free state and not as chloramines (chlorine combined with organic matter). Thus a much higher concentration can be tolerated without undue irritation and unpleasant odour and the chlorine is readily available for immediate attack on any fresh impurities which are introduced into the water.

Samples are taken at the various swimming baths in the City to check that an efficient treatment is being maintained. During the year under review 378 samples were taken for this purpose.

### Contract Samples

These are samples of various commodities used by Salford Corporation and are submitted by the Central Purchasing Committee to see that they conform to specification and to ensure that satisfactory products are obtained at competitive prices.

The 164 samples examined during 1965 consisted of synthetic detergents, soaps, polishes, scouring powders, sweeping compounds, solvents and various foodstuffs.

### Pharmacy and Poisons Act Samples

Only 2 products were examined under this Act: one sample of phenolic disinfectant and one of ammonia solution. Both were satisfactory as regards composition but both omitted to declare the name and address of the vendor on the label as required under the Act.

### Other Miscellaneous Articles

Several of the samples in this group were drinking waters about which complaints had been received—usually concerning the presence of insects or insoluble matter. The results of examination are in many cases passed on to the supplier, Manchester Corporation Waterworks, for them to take any necessary action.

Also included are such things as oil exuding from thermostats in new blocks of flats and thought to have come from the underfloor heating cables, liquid from bedroom floor, water from sub-floor cavity to trace the source and disinfectant to find the cause of premature corrosion of the containers.

## AIR POLLUTION

### Smoke and Sulphur Dioxide

The two main contaminants of urban air are smoke and sulphur dioxide. Since the Clean Air Act of 1956, great efforts have been made by many local authorities to reduce pollution of the air by smoke and, to a lesser extent, sulphur dioxide by introducing Smoke Control Areas.

Salford, together with other authorities, has for a number of years been participating in the National Survey of Air Pollution in collaboration with Warren Spring Laboratory of the Ministry of Technology. In this survey the smoke and sulphur dioxide concentrations are measured daily at various sites in the area.

The results for the six sites in Salford are given in the following tables. It is a pleasure to record once again that there has been a considerable reduction in these pollutants – particularly smoke. The average smoke concentration for Salford as a whole was 254 microgrammes per cubic metre of air as compared with 298 the previous year and 402 in 1961. Although this figure of 254 is still higher than is desirable, it is nevertheless nearly 40 per cent lower than it was in 1961 and represents a tremendous improvement over the past five years. The sulphur dioxide is 15 per cent lower than the 1961 level.

## TABLE 6

### Smoke Pollution

Average daily readings for the different months of the year

Results expressed as micro grammes per cubic metre of air

| Month 1965 | SITE | | | | | |
|---|---|---|---|---|---|---|
| | Regent Road | Cleveland House | Police Street | Murray Street | Encombe Place | Landseer Street |
| January | 532 | 231 | 399 | 362 | 371 | 420 |
| February | 373 | 229 | 326 | 346 | 328 | 455 |
| March | 381 | 246 | 338 | 328 | 244 | 312 |
| April | 200 | 92 | 221 | 206 | 82 | 204 |
| May | 254 | 72 | 158 | 124 | 57 | 146 |
| June | 68 | 48 | 114 | 86 | 47 | 108 |
| July | 164 | 75 | 152 | 118 | 63 | 130 |
| August | 169 | 81 | 149 | 120 | 110 | 154 |
| September | 335 | 145 | 245 | 227 | 172 | 261 |
| October | 350 | 340 | 378 | 376 | 244 | 323 |
| November | 429 | 196 | 454 | 504 | 309 | 375 |
| December | 568 | 288 | 397 | 445 | 370 | 508 |
| Daily average for the whole year | 319 | 171 | 278 | 270 | 200 | 283 |
| Average for 1964 | 406 | 208 | 318 | 289 | 255 | |
| 1963 | 421 | 246 | 356 | 300 | 286 | |
| 1962 | 512 | 300 | 408 | 333 | 331 | |
| 1961 | 548 | 307 | 429 | 372 | 352 | |

Overall Average 1965 = 254
1964 = 298
1963 = 320
1962 = 377
1961 = 402

## TABLE 7

### Sulphur Dioxide Pollution

Average daily readings for the different months of the year

Results expressed as micrammes per cubic metre of air

| Month 1965 | SITE | | | | | |
|---|---|---|---|---|---|---|
| | Regent Road | Cleveland House | Police Street | Murray Street | Encombe Place | Landseer Street |
| January | 528 | 140 | 380 | 380 | 486 | 521 |
| February | 465 | 208 | 424 | 353 | 468 | 518 |
| March | 409 | 264 | 412 | 346 | 475 | 416 |
| April | 299 | 121 | 277 | 219 | 181 | 353 |
| May | 358 | 143 | 205 | 176 | 121 | 272 |
| June | 97 | 119 | 180 | 151 | 124 | 178 |
| July | 191 | 81 | 178 | 141 | 167 | 224 |
| August | 184 | 108 | 178 | 126 | 181 | 199 |
| September | 244 | 100 | 242 | 187 | 178 | 254 |
| October | 277 | 274 | 328 | 280 | 354 | 251 |
| November | 343 | 204 | 400 | 393 | 585 | 395 |
| December | 380 | 197 | 307 | 350 | 305 | 550 |
| Daily average for the whole year | 315 | 163 | 293 | 259 | 302 | 344 |
| Average for 1964 | 361 | 170 | 319 | 275 | 311 | |
| 1963 | 385 | 189 | 358 | 303 | 344 | |
| 1962 | 439 | 193 | 367 | 300 | 356 | |
| 1961 | 472 | 158 | 294 | 326 | 388 | |

Overall Average 1965 = 279
1964 = 296
1963 = 312
1962 = 331
1961 = 328

## TABLE 8

### Smoke/Sulphur Dioxide Ratios

| Year | SITE | | | | | |
|---|---|---|---|---|---|---|
| | Regent Road | Cleveland House | Police Street | Murray Street | Encombe Place | Landseer Street |
| 1961 | 1.16 | 1.94 | 1.46 | 1.14 | 0.91 | – |
| 1962 | 1.17 | 1.55 | 1.11 | 1.11 | 0.93 | – |
| 1963 | 1.10 | 1.30 | 1.00 | 0.99 | 0.84 | – |
| 1964 | 1.12 | 1.22 | 1.00 | 1.05 | 0.82 | 0.98 |
| 1965 | 1.01 | 1.05 | 0.95 | 1.04 | 0.66 | 0.82 |

## Carcinogenic Hydrocarbons

The smoke stains from Regent Road are examined for the presence of certain polynuclear hydrocarbons which possess carcinogenic properties. Table 9 records the amounts of these compounds present.

TABLE 9

Carcinogenic Hydrocarbons in the Atmosphere

| Month 1965 | Micrgrammes Smoke per 100 cubic metres | Micrgrammes Hydrocarbon per 100 cubic metres of air | | | Parts per million Hydrocarbon in Smoke | | |
|---|---|---|---|---|---|---|---|
| | | Pyrene | Coronene | 3.4 Benzpyrene plus 1.12 Benzperylene | Pyrene | Coronene | 3.4 Benzpyrene plus 1.12 Benzperylene |
| Janauary | 39,900 | 5.1 | 0.4 | 6.2 | 127 | 10 | 157 |
| February | 32,600 | 3.2 | 2.5 | 13.8 | 97 | 77 | 423 |
| March | 38,100 | 2.8 | 0.36 | 5.9 | 220 | 29 | 459 |
| April | 8,200 | 0.9 | 0.9 | 0.7 | 109 | 104 | 84 |
| May | 5,740 | — | 0.08 | 0.92 | — | 14 | 160 |
| June | 10,800 | — | 0.06 | 1.40 | — | 5 | 130 |
| July | 13,020 | — | — | 0.41 | — | — | 31 |
| August | 16,900 | 0.64 | — | 2.85 | 38 | — | 169 |
| September | 33,400 | — | — | 7.39 | — | — | 221 |
| October | 35,000 | — | — | 6.05 | — | — | 519 |
| November | 43,000 | — | 2.6 | 17.9 | — | 174 | 1,248 |
| December | 56,800 | 6.72 | 2.4 | 15.6 | 354 | 126 | 825 |

### Radioactivity

Monitoring the air for radioactive matter commenced towards the end of 1965. This is done by drawing air through a filter for a period of about 7 days and determining the total beta activity of the particulate matter removed by the filter after allowing any natural radioactivity to decay.

The average total beta activity for the 8 samples was 0.011 picocuries per cubic metre of air compared with the limit of 33 picocuries per cubic metre recommended for large populations by the International Commission for Radiological Protection.

### Pollution of air by pigeons

To assess the degree of contamination of air by droppings from wild pigeons, a series of tests was carried out to measure the uric acid content of the suspended particulate matter in air.

Although avian faecal matter contains a high proportion of uric acid, the undesirable factor is not the uric acid but the pathogenic organisms which are also present.

Samples were collected over periods of one week using an apparatus similar to that recommended for the National Survey of Air Pollution. The suspended particulate matter is removed from the air by a filter paper and the uric acid is then extracted from this and determined by a colorimetric method. The results of these determinations are given in Table 10. It is seen that in all seven samples of air collected, significant amounts of uric acid were found, the average being 0.10 microgrammes per cubic metre of air.

TABLE 10

Concentration of Uric Acid in Air

| Dates of Samples | | Air Volume Cubic Metres | Microgrammes Uric Acid in samples | Concentration of Uric Acid Microgrammes per Cubic Metre |
|---|---|---|---|---|
| From | To | | | |
| 4.11.65. | 11.11.65. | 128 | 23.5 | 0.18 |
| 19.11.65. | 26.11.65. | 130 | 16.0 | 0.12 |
| 26.11.65. | 3.12.65. | 127 | 14.3 | 0.11 |
| 3.12.65. | 10.12.65. | 124 | 12.5 | 0.10 |
| 10.12.65 | 17.12.65. | 123 | 7.0 | 0.06 |
| 17.12.65. | 24.12.65. | 115 | 3.0 | 0.03 |
| 24.12.65. | 31.12.65. | 116 | 11.7 | 0.10 |

# DOMICILIARY MIDWIFERY SERVICE

Recruitment to our service has improved especially through our own Training School; several newly-qualified midwives remaining on our staff for a period of experience.

The problem of mothers leaving hospital within the first week is still with us. One cannot stress too much or too often the need for the home to be properly prepared for the reception of the new baby, and it must be remembered that the baby leaves a centrally-heated nursery to return to a home which has frequently remained unheated during the mother's stay in hospital. Too many mothers still take their own discharge from hospital earlier than advised.

The General Practitioners are gradually taking more responsibility for the ante-natal and post-natal care. Seven practices have now asked for a midwife to work with the doctor at his surgery during his weekly ante-natal session. This is increasing the co-operation between the doctor and midwife and is of great benefit to the mother– who attends one place only for ante-natal care, seeing both doctor and midwife at her visit.

Preliminary discussions have been held regarding the use of a 4-bedded wing of Hope Hospital as a "General Practitioner Unit" – This would allow for a selected group of mothers to be under the care of her own family doctor and midwife throughout her pregnancy, labour and post-natal period, with the actual delivery in the vicinity of the hospital where emergency help would be immediately available. A standing Committee has been formed to finalise these arrangements.

## ANALGESIA

Nitrous oxide has been available to mothers as an inhalation analgesia since 1933. This, combined with air, has proved very beneficial.

It has, however, been found that the subsequent reduction in oxygen could be a contributing factor producing anoxia in the foetus.

British Oxygen Co. have now produced (after many years of research) a method by which nitrous oxide and oxygen can be pre-mixed in one cylinder (50% ä̇ä̇) and the mixture has been authorised by the Central Midwives Board for use by midwives.

## TRANSPORT AND CONTACT

The chief problems of our service remain:– lack of transport for the individual midwife and the loss of contact with her once she has left her own home.

Suggestions that Salford Midwives should be considered for the "Assisted car purchase scheme" in line with other authorities have recurrently failed and midwives unable to purchase their own (without this help) continue to lose valuable time by delays in transport.

Although the transport difficulty remains it is hoped that, in the near future, a means of continuous contact within the service will be available through "two way radio".

## STATUTORY SUPERVISION OF MIDWIVES (Midwives' Act, 1951)

### Notification of Intention to Practise

In accordance with the provision of the above Act, the number of midwives who notified their intentions to practise was as follows :–

| | |
|---|---|
| (a) Institutional | 44 |
| (b) Domiciliary | 31 |
| (c) Private Practise | 1 |
| Total | 76 |

### Compulsory Post-Graduate Courses

In accordance with the rules of the Central Midwives Board, midwives have continued to attend, at least once in every five years, courses arranged for post-graduate instruction.

Attendance by Salford Midwives 1965

| | |
|---|---|
| (a) Institutional | 7 |
| (b) Domiciliary | 4 |
| (c) Supervisory | 1 |

These courses are held at various centres throughout the country and give excellent opportunity for discussing old and new ideas, the interchange of local innovations, and for meeting people in all fields of midwifery.

### Miscellaneous Notifications

(as required by the rules of the Central Midwives Board)

| Notification | Domiciliary | Private Practise | Total |
|---|---|---|---|
| Stillbirth | 4 | – | 4 |
| Death of Mother/Baby | 2 | – | 2 |
| Laying out of Dead Body | – | – | – |
| Infection | 23 | – | 23 |
| Medical Aid | 1,469 | – | 1,469 |

### STAFF POSITION (December 31st)

| | Establishment | 1965 | 1964 | 1963 |
|---|---|---|---|---|
| Supervisor and Tutor | 1 | 1 | 1 | 1 |
| Assistant Supervisor | 1 | 1 | 1 | 1 |
| Approved District Teachers | 5 | 5 | 5 | 3 |
| Midwives – Full-Time | 22 | 16 | 17 | 17 |
| Midwives – Part-Time | – | 3 | 4 | 3 |
| Breast-feeding Sisters | 2 | 2 | 2 | 2 |
| Premature Baby Sisters | 3 | 3 | 3 | 3 |

## STATISTICS

### (1) Clinics

| | | | |
|---|---|---|---|
| (a) Attendances :– | Statistics relating to ante-natal clinic attendances will be found under "Care of Mothers and Young Children". | | |
| (b) Bookings :– | Number of domiciliary bookings | 1,427 | (1,602) |
| | Number of cancellations (including removals, transfers to hospitals, etc.) | 536 | (443) |

### (2) Home Visiting

| | | | |
|---|---|---|---|
| (a) Follow-up of clinic defaulters<br>(b) Routine home ante-natal visits | | 10,742 | (10,286) |
| (c) Investigation of home conditions | | | |
| | Actual homes | 386 | (340) |
| | Number of visits | 1,660 | (1,844) |

COMPARATIVE STATISTICS – HOME INVESTIGATIONS

| Year | 1965 | 1964 | 1963 | 1962 | 1961 |
|---|---|---|---|---|---|
| Totals | 386 | 340 | 398 | 478 | 264 |

## BIRTHS

### (1) Statistics

| | | |
|---|---|---|
| Doctor booked and present at delivery | 71 | (108) |
| Doctor booked, not presnt at delivery | 1,031 | (1,090) |
| Doctor not booked, present at delivery | 2 | (0) |
| Doctor not booked, not present at delivery | 8 | (9) |
| | 1,112 | (1,230) |
| N.B. Domiciliary births formed (of total Salford birt hs) | 61.09 | (62.5%) |

COMPARATIVE STATISTICS

| Year | Live Births | Still Births | Total |
|---|---|---|---|
| 1961 | 1,241 | 7 | 1,248 |
| 1962 | 1,341 | 8 | 1,349 |
| 1963 | 1,222 | 12 | 1,234 |
| 1964 | 1,207 | 2 | 1,209 |
| 1965 | 1,108 | 4 | 1,112 |

| | | |
|---|---|---|
| Number of nursing visits following delivery | 18,385 | (20,003) |
| Number of nursing visits for hospital discharges | 6,714 | (6,393) |
| Total | 25,099 | (25,309) |
| Number of Discharges from hospital under 10 days | 953 | (970) |

**(2) Analgesia**

| | Number of Mothers |
|---|---|
| Nitrous Oxide | 1 |
| Trilene | 812 |
| Pethidene | 769 |
| Total Inhalation Analgesia | 813 i.e. 73.1% of all births |

**(3) Stillbirths**

| Comparative Statistics | Number of Stillbirths | Rate per 1,000 Registered Births |
|---|---|---|
| 1961 | 7 | 5.83 |
| 1962 | 8 | 6.0 |
| 1963 | 12 | 9.9 |
| 1964 | 2 | 1.25 |
| 1965 | 4 | 3.5 |

SUMMARY OF CASES

| Classification | Presentation | Weight | Gestation | Condition | Contributory Factors |
|---|---|---|---|---|---|
| Ante-Partum Anoxia 1 | Vertex | 6 lbs. 2 ozs. | 40 weeks | Early Maceration | Normal Pregnancy ? I.U.D. before onset of labour |
| 2 | Breech | 6 lbs. | 40 weeks | Macerated | Excessive infarction of placenta P.M. refused by parents |
| 3 | ? Vertex | 7 lbs. | 32 weeks | Macerated | B.B.A. Normal Pregnancy I.U.D. before onset of labour. No foetal abnormality |
| Intra-Partum Anoxia 1 | Vertex | 7 lbs. | ? 43 weeks | Fresh | Rapid 1st Stage F.H. Failed during labour. No foetal abnormality |
| Foetal Abnormalities NIL | | | | | |

**(4) Neo-natal Mortality (Domiciliary bookings)**

| Deaths from Birth up to 28 days | | Cause of Death | Age at Death |
|---|---|---|---|
| Born and died at home | 2 | (1) Cerebral Haemorrhage and foetal abnormality | 30 mins. |
| | | (2) Intra-Uterine Pneumonia and prematurity | 2 days |
| Born at home and transferred to hospital | 7 | (1) Asphyxia and Atelectasis | 20 hours |
| | | (2) Pneumonia and Prematurity | 2 days |
| | | (3) Spina Bifida | 2 weeks |
| | | (4) Congenital Laryngeal Stenosis | 16 hours |
| | | (5) Gastro-Enteritis (Mother Para : IX) | 3 weeks |
| | | (6) Prematurity and Respiratory Distress syndrome (Breech delivery) | 8 hours |
| | | (7) Congestive Heart Failure | 1 week |

| | | Reason for Transfer | Number |
|---|---|---|---|
| Mothers booked for home confinement and transferred to hospital before delivery | 10 | Ante-Partum Haemorrhage | 1 |
| | | Prematurity | 4 |
| | | Twin Pregnancy | 1 |
| | | Foetal distress in labour | 2 |
| | | Rhesus Negative with Antibodies | 1 |
| | | Positive Cervical Smear | 1 |

**(5) Puerperium**

| Infection | Hospital | Domiciliary | Total |
|---|---|---|---|
| Puerperal Pyrexia | 29 | 3 | 32 |
| Opthalmia Neonatorum | 1 | – | 1 |
| Pemphigus Neonatorum | – | – | – |

Causes of pyrexia were as follows :–

| | Hospital | Domiciliary | Total |
|---|---|---|---|
| Uterine Infection | 4 | 1 | 5 |
| Urinary Infection | 17 | – | 17 |
| Chest Infection | 1 | 2 | 3 |
| Undiagnosed Causes | 7 | – | 7 |

## OPTHALMIA NEONATORUM

One case of Gonococcal Opthalmia was notified from hospital. The babv was transferred to Ladywell Hospital for treatment and follow-up care.

## BREAST FEEDING AND PREMATURE BABY SERVICES

These two units, where the staff have remained stable for many years, continue as invaluable complementary services. The value of their experience is shown by their early diagnosis of many abnormalities and by the teaching and help given to individual mothers and babies referred for their care.

A total number of 2,209 visits were made and 204 clinic sessions attended.

## SALFORD PART II MIDWIFERY TRAINING SCHOOL

23 pupil midwives completed their training during the year and 20 are known to have taken posts in hospital or domiciliary midwifery after completion of training.

## JUTLAND HOUSE

It is known that Jutland House is unsuitable in every way as a home for nurses. They would not be human if they did not feel a certain amount of injustice when they see the new or improved accommodation provided in Salford for educational establishments and other services under this authority. Not only is the building itself a disgrace to our City but its situation is a most undesirable one for our younger nurses.

However, the training and experience gained in Salford sends each pupil well-equipped for all emergencies and therefore given some form of compensation.

# CARE OF MOTHERS AND YOUNG CHILDREN

## STATISTICS

The figures in this section are compiled locally and do not necessarily correspond with those supplied by the Registrar General.

### Births

During the year we received 4,202 live birth notifications, 261 of which referred to births outside the City to Salford residents. There were also 96 stillbirth notifications plus 1 stillbirth which was not notified; 7 of the stillbirths occurred outside the City to Salford residents.

The adjusted births for Salford were 3,090 live and 68 stillbirths; these figures, set against the Registrar General's estimated population of 148,260 for mid-1965 give an estimated Live Birth Rate of 20.8 and a stillbirth rate of 21.5 respectively; i.e. an appreciable drop in the stillbirth rate compared with 1964 when the stillbirth rate was 24.77.

Of the total notified births 73.9% were institutional, but of the births occurring to Salford mothers only 64.5% were hospital born. This is, however, an increase of 2.63% over the percentage for the previous year.

### Illegitimate Births

During the past ten years there has been an ever increasing proportion of illegitimate births and the table below shows the percentage of illegitimate births both nationally and in Salford.

Illegitimate live births as a percentage of total live births

| National % | Year | Salford % |
|---|---|---|
| 4.6 | 1955 | 5.8 |
| 4.8 | 1956 | 5.1 |
| 4.8 | 1957 | 5.8 |
| 4.9 | 1958 | 6.5 |
| 5.1 | 1959 | 5.7 |
| 5.4 | 1960 | 8.0 |
| 5.9 | 1961 | 8.3 |
| 6.6 | 1962 | 9.0 |
| 6.9 | 1963 | 10.21 |
| 7.2 | 1964 | 11.46 |
| ? | 1965 | 11.56 |

It is most disquieting to note that whereas the national figure has risen by 56.5% the figure for Salford has risen by 97.6%. This may in some part be due to the presence in Salford of two homes for unmarried mothers but it still remains apparent that Salford has not escaped the decline in moral values which has occurred throughout the country.

**Infant Deaths**

The total loss of infant life during 1965 was 68 stillbirths and 81 deaths during the first year of life.

The infant mortality rate is 26.3 per 1,000 registered live births (compared with 30.46 in 1964), and the stillbirth rate is 21.03 per 1,000 registered live and stillbirths (compared with 25.22 in 1964).

The following table shows the distribution of infant deaths by age, together with the death rates.

| | | | | | |
|---|---|---|---|---|---|
| Stillbirths | 68 | 115 Perinatal deaths | | | |
| Deaths under 24 hours | 31 | Perinatal mortality rate 36.41 | 47 early Neo-natal deaths Death Rate 15.2 | 54 Neonatal deaths Death Rate 17.4 | 81 Infant deaths Death Rate 26.3 |
| ,, 1 to 6 days | 16 | | | | |
| ,, in 2nd week | 3 | | | | |
| ,, in 3rd week | 3 | | | | |
| ,, in 4th week | 1 | | | | |
| ,, 1 to 5 months | 22 | | | | |
| ,, 7 to 11 months | 5 | | | | |

The infant mortality statistics for 1965 show an improvement in every age group when compared with the figures for 1964.

The table below shows the distribution of causes of death by age groups up to the age of 1 year :–

| | Under 1 day | 1 to 6 days | 1 to 3 weeks | 1 to 11 months | Total |
|---|---|---|---|---|---|
| Prematurity | 14 | 6 | – | – | 20 |
| Congenital Malformations | 3 | 1 | 3 | 1 | 8 |
| Birth Injury | 2 | – | – | – | 2 |
| Respiratory Disease | 10 | 9 | 1 | 20 | 40 |
| Accidental Deaths | 1 | – | – | 1 | 2 |
| Gastroenteritis | – | – | 1 | 1 | 2 |
| Other | 1 | – | 2 | 4 | 7 |
| TOTAL | 31 | 16 | 7 | 27 | 81 |

This table shows once again that Prematurity and Respiratory diseases are the principle causes of infant deaths in the early days of life. If there is to be a major improvement in the preservation of infant life our efforts must be directed towards the prevention of prematurity and the prevention and treatment of respiratory difficulties in the new infant.

**Deaths 1 to 4 years**

There were 9 deaths in the age group 1 to 4 years during 1965. This figure shows an improvement when compared with previous years, i.e. 11 deaths in 1964 and 19 deaths in 1963.

The table below shows the age distribution and the causes of death in children between 1 and 4 years.

| Cause of Death | Aged 1 year | Aged 2 years | Aged 3 years | Aged 4 years | Total |
|---|---|---|---|---|---|
| Respiratory Disease | 3 | – | – | – | 3 |
| Accidental Death | – | 1 | 1 | – | 2 |
| Infection | 1 | – | – | – | 1 |
| Other Causes | 1 | 1 | 1 | – | 3 |
| TOTAL | 5 | 2 | 2 | – | 9 |

The principle cause of death in this age group is respiratory disease: the number of accidental deaths has fallen from 5 in 1964 to 2 in 1965, both these deaths being due to motor vehicle accidents: there was one death due to infection (meningococcal meningitis) and there were three deaths due to "other" causes. There have been no deaths due to leukaemia or other malignant diseases during 1965.

The number of deaths occuring annually in the 1 to 4 year old age groups has now fallen to such an extent that it is no longer possible to identify trends in the pattern of early childhood mortality. One can, however, say that respiratory diseases and fatal accidents remain the major hazards to life for the pre-school child.

**Maternal Deaths**

During the year ended December 31st, 1965 two Salford mothers died from causes due to or associated with childbirth. In the first case the death was not directly attributable to the act of parturition but the mother died sixteen days after the birth of the child. In the second case the mother died as the result of a serious complication which occurred during operative delivery.

The maternal mortality rate for the city for 1965 is 0.63 per 1,000 registered births.

In 1964 there were no maternal deaths due to or associated with pregnancy, childbirth or abortion and in 1963 the figures showed that there were three deaths giving a maternal mortality rate of 0.92 per 1,000 registered births.

## ANTE-NATAL CLINICS

The number of expectant mothers attending local authority ante-natal clinics continues to fall, due not to a fall in the number of babies born in Salford, but to an increase in the number of general practitioners providing ante-natal facilities for their own patients on their own premises. This trend has been apparent for a number of years and in January, 1965 ante-natal

clinic facilities were withdrawn from Police Street Clinic and Regent Road Clinic, the patients who attended these clinics being transferred to other clinics convenient to them. At the year-end ante-natal sessions were held at Langworthy Centre and Murray Street twice weekly and at Kersal Centre, Ordsall Clinic, Summerville Clinic and Trinity Centre once per week with an additional "midwives only" session at Ordsall Clinic once per week. (Ante-natal clinics were transferred from Encombe Place Clinic to Trinity Centre in September, 1965 when Trinity Centre was opened to replace the ageing and inconvenient Encombe Place Clinic).

A total of 1,580 expectant mothers attended the clinic during the year (320 fewer than in 1964) and in all 8,370 attendances were made (1,391 fewer than in 1964). All the clinics, with the exception of Ordsall Clinic which takes patients from the Regent Road area, show a decline in the number of mothers attending and the decline is most noticeable at Murray Street Clinic, possibly due to large-scale demolition in the area.

The table below shows the work done at each ante-natal clinic and also a comparison with the work done in the previous year. It should be noted that the figures refer only to ante-natal patients examined at local authority ante-natal clinics. General practitioners are employed on a sessional basis to carry out consultations at ante-natal clinics but at the present time no general practitioner uses local authority premises for ante-natal sessions limited to his own patients.

1965 ANTE-NATAL CLINIC SUMMARY

| Clinic | No. of Sessions weekly | Total individuals attending | Total attend-ances | New Attenders | L.A.M.O. Consultations | G.P. Consult-ations |
|---|---|---|---|---|---|---|
| Trinity* | 1 | 122 | 670 | 88 | 140 | 23 |
| Kersal | 1 | 156 | 966 | 117 | 31 | 173 |
| Langworthy | 2 | 414 | 2,242 | 325 | 254 | 228 |
| Murray St. | 2 | 453 | 1,998 | 361 | 249 | 296 |
| Ordsall | 2 | 290 | 1,656 | 229 | 300 | – |
| Summerville | 1 | 145 | 838 | 107 | 26 | 156 |
| TOTAL | 9 | 1,580 | 8,370 | 1,227 | 1,000 | 876 |
| 1964 TOTAL | 10 | 1,900 | 9,761 | 1,478 | 2,044 | 277 |

* Transferred from Encombe Place, October, 1965

**Ante-Natal Blood Tests**

The number of routine blood samples taken at the ante-natal clinics was as follows :–

For Wasserman, P.P.R. and R.P.C.F. testing 930: of which 5 were reported positive.

For Haemoglobin estimation 1,753. This test is carried out twice during pregnancy as a routine and more frequently if the patient is having treatment for anaemia.

For the Rhesus Factor 816 of which 756 were reported positive and 60 were reported negative. These latter were invited to the Rhesus Clinic for further testing.

The number of mothers invited to the Rhesus Clinic for re-testing and antibody tests was 168. This figure includes (a) all those who were reported negative on routine testing at the clinics, (b) all those who are known to be Rhesus Negative following blood tests during a previous pregnancy, (c) those who had preliminary blood tests at Hope Hospital Ante-natal Clinic and who were referred for repeat testing when home confinement was advised.

The number of mothers requiring Rhesus testing has fallen in the past four years and the clinic is now held fortnightly instead of weekly as in previous years.

The number of patients found to be Rhesus positive on re-testing was 30 and in 138 cases the patients were confirmed as having Rhesus negative blood.

Antibody testing showed that 7 mothers had Anti D antibodies and 5 mothers had other antibodies. The outcome of the pregnancies of mothers with Anti D antibodies is as follows :–

(a) one stillbirth,

(b) one early neo-natal death,

(c) three infants required exchange tranfusions at birth,

(d) two infants were reported well at birth.

In addition one infant born to a mother with Anti C and Anti E antibodies was severely affected by haemolytic disease and required three blood transfusions.

We have had no difficulties during the year in persuading mothers with antibodies to go into hospital for confinement possibly because Hope Hospital now offers admission with early discharge home when both mother and child are fit and well.

### Post-natal Clinics

No local authority post-natal clinics are held in this City and there have been no requests for post-natal examinations for individual mothers.

## CHILD WELFARE CLINICS

The highlight of the year was the opening in October of the new, purpose-built Trinity Centre, which replaced the old inconvenient premises at Encombe Place.

The number of clinic sessions increased from 22½ sessions per week in 1964 to 23½ sessions per week in 1965. The figures show that the total number of attendances has increased at all centres, except Cleveland House

and Kersal Centre and that the total number of individuals attending the clinics has risen at all the clinics without exception. The numbers of new cases attending the clinics shows a slight increase at all centres except Kersal 183 new cases (cf. 187 in 1964) and Regent Road 324 new cases (cf. 334 in 1964).

The table below shows the distribution of work throughout the clinics (the figures in brackets relate to 1964).

CHILD WELFARE CLINIC SESSIONS, 1965
(Figures in brackets relate to previous year)

| Clinic | Weekly Sessions | Attendances | Individuals | New Cases | Consultations | Referrals |
|---|---|---|---|---|---|---|
| Cleveland | 2 | 2,042 (2,200) | 391 (353) | 150 (148) | 280 (313) | 22 (10) |
| Trinity | 2 | 1,561 (1,443) | 370 (343) | 169 (162) | 338 (371) | 50 (34) |
| Kersal | 2 | 2,627 (3,260) | 448 (434) | 183 (187) | 403 (419) | 26 (29) |
| Langworthy | 4 | 8,303 (7,513) | 1,616 (1,440) | 756 (671) | 1,578 (1,786) | 118 (136) |
| Murray Street | 3 | 5,593 (5,462) | 1,333 (1,252) | 733 (701) | 944 (1,194) | 175 (162) |
| Ordsall | 2 | 2,385 (2,266) | 496 (430) | 237 (214) | 384 (588) | 49 (46) |
| Police Street | 3 | 3,139 (2,923) | 611 (580) | 279 (254) | 555 (584) | 21 (23) |
| Regent | 3 | 2,924 (2,845) | 639 (618) | 324 (334) | 411 (464) | 40 (36) |
| Summerville | 2 | 2,674 (2,516) | 380 (352) | 145 (165) | 289 (388) | 31 (54) |
| Premature Baby | ½ | 67 (119) | 22* (21) | 15 (32) | 67 (119) | 3 (1) |
| *Plus 17 who have also attended other Salford C.W.C. | | | | | | |
| Totals | 23½ | 31,315(30,547) | 6,306 (5,823) | 2,991 (2,868) | 5,249 (6,226) | 535(531) |
| Removed out in 1965 | | | 281 (293) | | | |
| Clin attenders died in 1965 | | | 5 (11) | | | |
| Attended and reached5 years old in 1965 | | | 111 (109) | | | |
| Grand Totals 1965 | | 31,315 | 6,703 | 2,991 | 5,249 | 535 |
| Grand Totals 1964 | | 30,547 | 6,270 | 2,868 | 6,226 | 531 |
| Grand Totals 1963 | | 32,575 | 5,985 | 2,812 | 5,778 | 511 |

The average number of attendances at the clinics per child on the register (0 – 5 years) was 5.4 per annum and this can be analysed to show that infants under 1 year of age made 7.3 attendances at the clinic, children between 1 and 2 years of age made 6.5 attendances and children between 2 and 5 years made 2.5 attendances. These figures relate to children on the clinic register and not to the total child population of Salford. The percentage of Salford children under 5 years of age who attended the clinics at least once during 1965 is 51% and this can be further broken down to show that 64% of the 0 to 1 year, 66% of the 1 to 2 years and 30% of the 2 to 5 years attended child welfare clinics.

Medical staff attended 53% of the total number of clinic sessions, and the figures show that medical consultations were held in 22.6% of attendances in the 2 to 5 years old age group, 14.5% of attendances in the 1 to 2 year old age group and 16.5% of attendances in the under 1 year old age group. These figures are summarised in the table below.

| Age Group | Estimated Salford Population | Individual Attenders during year | % of Salford Age Group | Total Attendances during year | Average Attendance per Child Attending | Medical Consultations | % of Clinic Attendances | Referrals Elsewhere | % of Medical Consultations |
|---|---|---|---|---|---|---|---|---|---|
| 0 – 1 year | 2,882 | 1,988 | 64% | 13,403 | 7.3 | 2,153 | 16.5% | 91 | 4.2% |
| 1 – 2 years | 2,708 | 1,971 | 66% | 11,703 | 6.5 | 1,692 | 14.5% | 131 | 7.7% |
| 2 – 5 years | 7,454 | 2,744 | 30% | 6,209 | 2.5 | 1,403 | 22.6% | 313 | 22.3% |
| 0 – 5 years | 13,044 | 6,703 | 51% | 31,315 | 5.4 | 5,249 | 10.7% | 535 | 10.2% |

During the year the policy of holding Child Health Clinics was extended to all medically staffed sessions and a mother now has the opportunity to bring school child, toddler and baby to the same clinic session.

Specialist clinics staffed by hospital consultants and held on local authority premises have been held for premature babies, general paediatric and orthopaedic conditions. The latter clinics have dealt with a similar number of referrals and attendances as in the previous year, but the premature baby clinic has been less busy: fewer children have attended and the average attendance per child has been lower. This may possibly be due to the fact that the clinic is held at 10.00 in the morning and this may well be an inconvenient time for mothers with young babies.

Again we have received good co-operation from the hospital services in the area : 1,673 reports were received and as is usual approximately 50% were in respect of children aged under 1 year.

Migration still necessitates considerable follow-up work to ensure that records are forwarded to and received from the appropriate Authorities. All records for "untraced" children are maintained as individual portfolios awaiting requests from the new home areas. During the year 1,634 children were known to have left the City of which 966 were "known" removals and 593 children were known to have moved into the City. Re-housing within the City led to transfer of 340 records from one clinic to another (i.e. 5% of children attending clinics). Because of the considerable movement of population a new method of notifying school welfare officers of children attaining school age was started during the year and is working to the satisfaction of all taking part.

Over the past 5 years 15,794 birth notifications relating to Salford citizens have been received, 449 of these resulted in infant deaths : 4,270 children in this group were known to have left the City and 1,969 children

known to have moved in. On balance it is estimated that 13,044 children under 5 years of age reside in the City (2½% less than at 31st December, 1964).

## WELFARE AND PROPRIETARY BRAND FOOD SALES

The sales of proprietary brand foods continue to increase and it is apparent that mothers prefer to buy proprietary brands of baby food and to obtain their milk subsidy in the form of liquid milk rather than to buy National Dried Milk and to forego the subsidised liquid milk. A total of 26,529 tins of National Dried Milk were sold this year and this is only 32.5% of the sales of this product in 1954 when welfare food sales were transferred to local authorities. Five proprietary dried milks and two evaporated milks are stocked and as may be expected the lower-priced brands are the most popular.

Eleven varieties of cereal foods are stocked and sales have increased by 20% this year compared with the previous year. The ease of preparation of these foods, particularly so in the case of baby rice, helps busy mothers in the weaning period.

Orange juice sales are estimated to be 7.8% of optimum uptake and the table below shows the sales of orange juice since 1959.

SALES OF ORANGE JUICE 1959 – 1965

| Year | No. of bottles sold | % uptake |
|---|---|---|
| 1959 | 73,580 | 38.32 |
| 1960 | 70,152 | 37.22 |
| 1961 | 43,024 | 33.6 in 1st quarter of year<br>6.0 in 3rd and 4th quarters |
| 1962 | 26,957 | 6.7 |
| 1963 | 28,776 | 6.9 |
| 1964 | 29,481 | 7.2 |
| 1965 | 31,663 | 7.8 |

In the years preceding 1961, orange-juice was sold on coupons at 5d. per bottle and the average number of bottles sold was approximately 72,000 per annum, representing approximately 38% of the estimated uptake. In 1961 the price of the orange juice was raised to 1s. 6d. per bottle and in spite of a vigorous national campaign the effect on sales was almost disastrous. In 1961 only 43,024 bottles were sold and this represented in the first quarter of the year 33.6% of the estimated uptake and in the 3rd and 4th quarters of the year only 6% of the estimated uptake.

Since 1961 the sales of orange-juice have shown a slight tendency to rise but the sale of orange-juice in 1965 was less than 50% of the sale in 1960. In the latter half of 1961, the sales of proprietary preparations of Vitamin C doubled and since 1961 these sales have continued at a high level. It is quite obvious that whilst mothers considered orange-juice as an economical source of Vitamin C when it cost only 5d. per bottle, at 1s. 6d. per bottle it is in direct competition with mass advertised proprietary products in the same price range.

The sales of cod liver oil remain steady at 2.6% of the estimated uptake and the table below shows the pattern of sales since 1959 :–

SALES OF COD LIVER OIL 1959 to 1965

| Year | Number of bottles | Estimated Uptake |
|---|---|---|
| 1959 | 8,902 | |
| 1960 | 8,501 | 7.26% |
| 1961 | 5,892 | 8.4% in 1st quarter<br>3.3% in 3rd and 4th quarters |
| 1962 | 3,203 | 3.3% |
| 1963 | 2,875 | 2.9% |
| 1964 | 2,502 | 2.6% |
| 1965 | 2,547 | 2.6% |

The sales of cod liver oil showed a fall in 1961 when a charge of one shilling per bottle was introduced and sales of this product are now less than a third of the total distributed free in 1959. During 1965 mint flavoured cod liver oil was offered at the clinics in an attempt to improve the acceptance rate of cod liver oil, but the scheme was a failure.

The sale of vitamin A and D tablets has shown a slight improvement this year, the uptake being 17.9% of the estimated figure as shown in the table below :–

SALES OF A AND D TABLETS 1959 to 1965

| Year | Number of Packets Sold | Estimated Uptake |
|---|---|---|
| 1959 | 7,281 | |
| 1960 | 7,373 | 27.37% |
| 1961 | 6,160 | 28.00% in 1st quarter<br>16.20% in 3rd and 4th quarters |
| 1962 | 4,997 | 16.80% |
| 1963 | 4,756 | 16.25% |
| 1964 | 5,041 | 17.30% |
| 1965 | 4,835 | 17.90% |

There was a fall in the sales in 1961 when a charge of 6d. per packet was introduced and at the present time sales of A and D tablets are rising slowly. It should be noted that Hope Hospital Ante-Natal Clinic is the best sales centre and this must be related to the fact that many of the ante-natal patients attending the hospital are expecting babies for the first time and are particularly receptive to advice and guidance.

In addition to baby foods, fourteen proprietary preparations containing vitamins or minerals are stocked at the clinics and preparations of vitamin C are especially popular possibly because by the mere addition of cold, previously boiled, water the preparations are ready to give to baby.

Members of the W.V.S. have continued to maintain distribution of welfare

vitamins at the busy ante-natal sessions at Hope Hospital. This year, however, Mrs. Ellis, who was a founder-worker in this venture, decided that she was unable to continue and it is only fitting that we should officially record her service which was carried out so willingly and so efficiently and with a conscientiousness and concern for her clients which was an example to all workers in the field of voluntary service.

## VOLUNTARY ORGANISATION MOTHER AND BABY HOMES

There are two voluntary Mother and Baby Homes in Salford and both are visited at regular intervals by a member of the medical staff.

The rebuilding and alterations at St. Teresa's Home are now complete and the Home has accommodation for 32 babies and fifteen mothers in the new wing, each mother having her own room. The babies are accommodated in 4 nurseries on the ground floor of the new wing and there are also 4 isolation rooms for sick infants, a centrally placed milk-feed kitchen, a doctor's room and two baby bathrooms each with an adjoining sluice room and a washing room. The layout of the ground floor, which is entirely devoted to the care of the infants, appears to be ideally suited for this purpose, particular attention being paid to the elimination of the dangers of cross infection and food borne infections.

The convent building, previously used for the mothers and babies, is now to be used for expectant mothers over 16 years of age, and the ground floor nurseries have been altered to provide communal dining and lounge facilities for both expectant and nursing mothers.

A recent unhappy development in this field is the increase in the numbers of expectant mothers under 16 years of age. These mothers are cared for in the main convent building and these girls are now having lessons for an hour, twice daily, under the tutorship of a nun of the Order of St. Vincent de Paul.

The Salvation Army Mother and Baby Home continues to work in caring for the unmarried mother and her child. Here too the problem of the schoolgirl mother arises from time to time and the Matron of the Home has arranged for these young girls to have tuition from a trained teacher at regular times.

It is apparent that both the Mother and Baby Homes in Salford are well run and that all precautions to prevent infection are carried out. The standards of cleanliness in both homes are of the highest degree and the spirit of dedication, which all the workers show, must be a source of comfort and inspiration to the mothers.

## DENTAL SERVICE (MOTHERS AND YOUNG CHILDREN)

Owing to the sudden and unexpected death of the Principal School Dental Officer, no report on this service is available. It is, however, apparent from the figures which were submitted to the Ministry of Health on Form L.H.S.27/7 in February, 1966, and which are reproduced on the next page, that this service continued during 1965 along the lines laid down in previous years.

## Dental Services for Expectant and Nursing Mothers and Children

### Dental Treatment — Number of Cases

| | Number of persons examined during the year | Number of persons who commenced treatment during the year | Number of courses of treatment completed during the year* |
|---|---|---|---|
| Expectant and nursing mothers | 77 | 75 | 67 |
| Children aged under 5 and not eligible for school dental service | 322 | 286 | 266 |

*If a patient has more than one course of treatment during the year, each course is counted.

### Dental Treatment Provided

| | Scalings and gum treatment | Fillings | Silver Nitrate Treatment | Crowns and inlays | Extractions | General anaesthetics | Dentures provided | | Radiographs |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Full upper or lower | Partial upper or lower | |
| Expectant and nursing mothers | — | 35 | — | — | 67 | 21 | 5 | 2 | — |
| Children aged under 5 years and not eligible for school dental service | 8 | 67 | 284 | — | 355 | 141 | — | — | — |

Notes. Figures refer to number of treatments and not to number of persons.

### Number of Premises and Sessions

| | |
|---|---|
| Number of dental treatment centres in use at end of year for services shown above | 4 |
| Number of dental officer sessions (i.e. equivalent complete half days) devoted to maternity and child welfare patients during the year | 30 |

## ADOPTION MEDICAL EXAMINATIONS

During the year, eleven infants and young children were examined under the regulations of the Adoption Act, 1958 by medical officers on the staff of the Health Department and in each case the child was considered to be suitable for adoption.

During 1964, eleven children were examined for purpose of adoption and in 1963 seventeen children were medically examined for this reason.

In addition to this an unspecified number of children were medically examined at the request of the Children Officer prior to their being taken into the care of the local authority. Arrangements of this kind are made on an informal basis between the Child Care Officer involved and the Medical Officer on duty at the most convenient clinic. Following examination the doctor gives a short written report on the condition of the child which incorporates advice on any medical treatment the child may require.

## CYTOLOGY

During 1965, a total of 2,244 women were invited for Cervical Smear tests and of this number only 1,147 attended (including 23 who attended for repeat tests).

The women who attend for the test range from 25 – 65 years of age, although there are a few both younger and older.

The work has increased considerably and three clinics have been held weekly frequently throughout the year – instead of two clinics per week as in the previous years. All invitations are by appointment and clinics are held in the mornings, afternoons or evenings, the women being given the opportunity to indicate their preference. Every effort is made to invite the patients to a clinic which is readily accessible from their homes or places of work.

During 1965, 17 smears were reported as showing "Early Malignancy". This is an indication that these 17 women would have developed Cancer of the Cervix by the time they were 40 – 50 years old and by then it might well have reached the stage of being incurable. By this method of early detection these 17 women have been prevented from developing this disease. It is worth reporting that one patient was so pleased, yes pleased, that the early malignancy had been found in time to have it treated locally that she spread the news to her friends. It would be a good thing if more women took this view.

It has been said that it takes only a few minutes to take the test and this is true: the actual technique of taking the smear takes about 2 minutes, BUT there is a great deal more to it than that. Most patients are apprehensive when they come to see a doctor, and these women are no different. The Sister who receives them takes a factual history and tries very hard to put them at ease and the doctor adds medical details to this history and explains what is being done. First the breasts are examined for the possibility of an undetected Cancer being found there and then the Cervical Smear is taken. By this time the patients are much more relaxed and less fearful. Afterwards a few words concerning the date when the report may be expected are given: the whole procedure is, of necessity, at least 10 minutes per patient.

During 1965, five women were found to have 'lumps' in the breast. None of these had previously been noticed by the patients and one is known to have been operated on since and found to be non-malignant.

Since this work began in 1963 a total of 5,218 women have been invited for this test, but only 2,156 have attended. Why do the others not come?

(1) Are they afraid to find out that something may be wrong?

(2) Or, do they know something is wrong but are afraid to be told that it is cancer?

(3) Do they think it better to "suffer in silence" than to have the condition treated?

(4) Do they think that as they have never been ill they could not possibly develop Cancer?

(5) Are our facilities sufficiently well-known to the women of Salford?

Those who have attended are very relieved and surprised at the quickness and simplicity of the actual examination and often before they leave they turn to the doctor and say "May I ask you something doctor?" and then a second reason for attending comes to light. The women often feel their G.P.'s are too busy to be bothered with their "trivial worries" and many women still feel apprehensive about discussing their sexual problems with their family doctor, especially as in many cases, the doctor is a man.

The following table gives an indication of the work done during 1965, and the results of the tests.

## ATTENDANCES AND FINDINGS

| Clinic | Sessions | Invited | Attended | Non Salford Patients | Total Defects | BREASTS | | RESULT OF THE CERVICAL SMEAR | | Repeat Test Requested | Not Taken | Patients who had had a previous smear |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Normal | Defect | Normal | Early Malignancy | | | |
| Kersal | 1 | 15 | 9 | – | 14 | 9 | – | 9 | – | – | – | 1 |
| Langworthy | 47 | 968 | 488 | 91 | 557 | 482 | 4 | 479 | 9 | 11 | 2 | 14 |
| Murray Street | 10 | 197 | 107 | 23 | 109 | 107 | – | 107 | – | 3 | – | – |
| Police Street | 1 | 20 | 8 | – | 17 | 8 | – | 8 | – | 1 | – | – |
| Regent Road | 43 | 901 | 454 | 136 | 487 | 450 | 4 | 447 | 7 | 7 | 4 | 20 |
| Summerville | 5 | 100 | 55 | 14 | 53 | 55* | 1 | 55 | – | 1 | – | 1 |
| Trinity | 2 | 43 | 26 | 2 | 12 | 25* | 2 | 25 | 1 | – | – | 1 |
| TOTALS | 109 | 2,244 | 1,147 | 266 | 1,249 | 1,136 | 11 | 1,130 | 17 | 23 | 6 | 37 |

* In the Breasts here one had been removed and the remaining Breast was normal
Defect in the Breast includes previous Radial Mastectomy and "masses" found

| Age Group | Attended | Non Salford | Total Defects | RESULTS OF THE CERVICAL SMEAR | | Repeat Test Requested | BREASTS | | Spinster |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Normal | Early Malignancy | | Normal | Defect | |
| Under 25 years | 120 | 10 | 165 | 118 | 2 | 2 | 119 | – | 8 |
| 25 – 34 | 401 | 81 | 507 | 396 | 5 | 6 | 397 | 2 | 6 |
| 35 – 44 | 354 | 95 | 355 | 348 | 6 | 6 | 352 | 2 | 14 |
| 45 – 54 | 194 | 60 | 164 | 192 | 2 | 8 | 193 | 3 | 10 |
| 55 – 64 | 75 | 20 | 57 | 73 | 2 | 1 | 73 | 4 | 1 |
| 65 and over | 3 | – | 1 | 3 | – | – | 2 | – | – |
| TOTALS | 1,147 | 266 | 1,249 | 1,130 | 17 | 23 | 1,136 | 11 | 39 |

In the "Repeat Test Requested" column are all those who for any reason have attended more than once. Amongst those "Not taken" are the few who were pregnant when they came for the test and also those who have had a total hysterectomy.

A few women have had previous smears taken abroad or some years ago at a Family Planning Clinic.

The age group table also shows an interesting age distribution. The younger women are very much aware of the danger of undetected Cancer and it is indeed a pointer that 11 out of the 17 "early malignancy detected" are in the age group 25 – 44. It must be stressed that in practically all these 17 women there was little or nothing on the clinical examination to suggest Cancer. It has indeed been found very early.

## "HANDICAPPED" REGISTER

At the year end there were 337 children on the handicapped register. This figure is made up as below :–

| | |
|---|---|
| Number of children on register at 31st December, 1964 (corrected figure) | 313 |
| Number of new notifications during 1965 | 144 |
| Total number of children followed up during the year | 457 |
| Number removed from the register | 120 |
| Number on the register at 31st December | 337 |

Information about physically and mentally handicapped children comes to the Child Health Section from a wide variety of sources, e.g. from the Register of Congenital Malformations (56 referrals), from hospital discharge letters and from Health Visitors and Medical Officers; and the children on the register are followed up at regular intervals by Health Visitors. Information about the handicapped children is recorded on individual record cards which are filed centrally.

The following table shows the number of children on the handicapped register at 31st December, divided into categories. The table also shows the total number of new notifications during 1965, the number of new notifications remaining on the register at the year end, together with the reasons why a newly notified child was removed from the register. (Note that where a child suffers from a multiple handicap the child is included in the category of the major defect).

## 'HANDICAPPED' REGISTER

| Category | Total No. on Register at 31.12.65 | Cases notified during 1965 | Cases notified during 1965 and removed from Register in same year | | | Cases notified during 1965 and remaining on register at 31.12.65. |
|---|---|---|---|---|---|---|
| | | | Death | Left the District | Others | |
| Blind | 2 | 2 | – | – | – | 2 |
| Partially sighted | 7 | 6 | – | – | 2 | 4 |
| Other eye defects | 3 | 2 | – | – | – | 2 |
| Deaf | 4 | 2 | – | – | – | 2 |
| Partial hearing | 2 | – | – | – | – | – |
| Delicate respiratory | 12 | 6 | – | – | – | 6 |
| ,, circulatory | 41 | 13 | – | 1 | – | 12 |
| ,, gastro intestinal | 22 | 12 | – | 1 | – | 11 |
| ,, genital urinary | 15 | 9 | – | – | – | 9 |
| ,, other | 30 | 9 | – | – | – | 9 |
| Epileptic | 9 | 6 | – | 1 | – | 5 |
| Convulsions | 17 | 4 | – | – | – | 4 |
| Mentally retarded | 54 | 18 | – | – | – | 18 |
| Cerebral palsy | 12 | 4 | – | – | – | 4 |
| Organic diseases of central nervous system | 38 | 20 | 1 | 1 | 1 | 17 |
| Orthopaedic defects | 56 | 23 | – | 1 | – | 22 |
| Cleft palate | 10 | 6 | 1 | 1 | – | 4 |
| Speech defect | 1 | 1 | – | – | – | 1 |
| Socially handicapped | 2 | 1 | – | – | – | 1 |
| TOTALS | 337 | 144 | 2 | 6 | 3 | 133 |

At the age of 2 years handicapped children are referred either to a School Medical Officer for consideration for special educational treatment or to the Mental Health Section for care and guidance under the provisions of the Mental Health Act.

During the year, 61 children were referred to a School Medical Officer, 4 children were referred to the Mental Health Section, and 13 children were referred both to a School Medical Officer and to the Mental Health Section.

There are 35 children on the register who suffer from two or more handicaps and in the main these children suffer from a mental handicap combined with a physical handicap. There are 54 children on the register who suffer from some degree of mental handicap and of these children 14 suffer one additional handicap and 5 suffer from two additional handicaps. In this group of nineteen mentally handicapped children, 6 children suffer from congenital heart disease (one of whom also suffers from a hearing defect), 3 children suffer from an organic disease of the nervous system (one of whom also suffers from partial sight), 4 children come from severely disturbed home backgrounds (one of these children is blind and another is partially sighted), 3 children suffer from convulsions (one of whom also has an orthopaedic defect), 1 child suffers

from cerebral palsy and two children suffer from disorders of the gastro-intestinal tract. Other children suffering from multiple handicaps include 10 children with organic defects of the nervous system (including 3 mentally handicapped children noted above) and 9 children with heart disease (including 6 mentally handicapped children).

During the year, 120 children were removed from the handicapped register for the following reasons :–

(a) 38 children removed to addresses outside Salford

(b) 8 children died

(c) 11 children were cured

(d) 63 children reached the age of five years. Arrangements for the education of these children was made as follows :–

| | |
|---|---|
| Admission to ordinary day school | 24 |
| ,, Open Air School | 4 |
| ,, Partially Sighted Unit | 4 |
| ,, Residential School for the Blind | 1 |
| ,, Residential School for the Deaf | 3 |
| ,, Day Special School for the Deaf | 2 |
| ,, Oaklands School | 6 |
| ,, Parkfield Unit | 7 |
| ,, Wilmur Avenue Centre | 8 |
| Awaiting a place in Wilmur Avenue Centre | 1 |
| No Information | 3 |

In addition to these placements, 10 children under 5 years of age attended Wilmur Avenue Centre and 6 children under 5 years of age attended special school (3 children at the Royal Residential School for the Deaf; 1 child at Greengate Special Nursery School and 2 children at Oaklands Special School).

The work of maintaining the register of handicapped children is time consuming and the work of following up the children is arduous : perhaps more so than in other areas because of the frequency with which some families change their addresses. It has been estimated that in Salford 30% of the children have at least one change of address before reaching the age of 5 years.

## "AT RISK" REGISTER

The number of children on this register continues to rise and at the end of the year there were 773 children under observation on the 'At Risk' Register. During the year there were 464 new notifications and these were divided into the following categories :–

| | |
|---|---|
| Abnormal births | 207 |
| Prematurity | 123 |
| Anoxia at birth | 37 |
| Mother Rhesus Negative with Antibodies | 20 |
| Minor congenital malformations | 18 |
| Head Injuries | 9 |
| Post meningo-encephalitis | 8 |
| Other conditions e.g. haemolytic disease of the new born, maternal disease, birth injury, etc. | 42 |

During the year, 256 names were removed from the register for the following reasons :—

| | |
|---|---|
| Reached 2 years of age without developing any significant abnormality | 172 |
| Deceased | 3 |
| Transferred to the Handicapped Register | 4 |
| Removed from the district | 56 |
| Untraced | 21 |

The work of following up all the children on the 'At Risk' Register is arduous and in the past two years only 6 children have been transferred from the 'At Risk' Register to the Handicapped Register, i.e. have developed a significant defect which constitutes a handicap. It would appear that the criteria for selecting children to go on the 'At Risk' Register are too broad and it has been decided that in the future selection will be more tightly controlled. The children on the register will include premature infants weighing less than 4½ lbs. at birth, infants with anoxia at birth, infants born by operative delivery, infants born to mothers with Rhesus antibodies or certain specified diseases, etc., but infants born by forceps delivery will be included on the register only if the child is affected in some way. By this means we hope to reduce the amount of professional time which is spent maintaining this register without reducing its efficiency in enabling us to identify handicapped children at an early stage.

## REGISTER OF CONGENITAL MALFORMATIONS

During the past year information relating to live born and stillborn infants suffering from congenital malformations has been collected from a variety of sources and relayed to the office of the Registrar General as requested in November 1963. Information about these malformed children is obtained from (a) the birth notification cards which have been amended to include requests for information required by the Registrar General, (b) the weekly death sheets supplied by the local registrar which contain information about still-births and early neo-natal deaths due to congenital malformations which may not always be immediately available at the time of birth to the midwife completing the birth notification card, and (c) hospital discharge letters relating to infants who are found on medical examination during the early neo-natal period to have congenital malformations not immediately apparent at the time of birth. The information relayed to the Registrar General does not include the names or addresses of malformed infants, but each infant is identified by a code number so that reference to the child's future progress and development may be made in the future should it be so desired.

The total number of children suffering from congenital malformations noted at birth or shortly after birth and notified to the Medical Officer of Health during 1965 is 100. Of these, 12 children suffered from 2 or more malformations and 88 children suffered from a single malformation. In this group of 100 children there were 19 still-births and there were 8 early neo-natal deaths.

For the purposes of follow-up during infancy and childhood,

(a) 56 children were put on to the Handicapped Register, and at the year end 55 children remained on the Handicapped Register, one child having died before reaching the age of one month.

(b) 14 children were put on the At Risk Register for observation during infancy.

(c) 3 children were considered to have such trivial defects that no follow-up was indicated.

The following table shows the numbers of malformed infants (by the Registrar's classification) and the numbers of still-births, early neo-natal deaths, infant deaths and the method of follow-up.

(Note: Where a child has a double or treble defect, the child is counted in the category of the major defect)

| Registrar's Classification | Number of Children notified | Number of Children with Single Defect | Number of Children with 2 or more Defects | No follow-up | | Handicapped Register | | Other follow-up |
|---|---|---|---|---|---|---|---|---|
| | | | | Still-births | Neo-natal deaths | Alive and Well | Died | |
| 0 Central Nervous System | 36 | 28 | 8 | 17 | 4 | 13 | 1 | 1 |
| 1 Eye and Ear | 2 | 2 | – | – | – | 1 | – | 1 |
| 2 Alimentary System | 5 | 3 | 2 | – | – | 5 | – | – |
| 3 Heart & great vessels | 2 | 2 | – | – | – | 2 | – | – |
| 4 Respiratory System | 2 | 2 | – | – | 1 | 1 | – | – |
| 5 Urogenital System | 16 | 16 | – | – | 1 | 7 | – | 8 |
| 6 Limbs | 20 | 20 | – | – | – | 17 | – | 3* |
| 7 Other Skeletal | 5 | 4 | 1 | – | 2 | 3 | – | – |
| 8 Other Systems | 5 | 5 | – | – | – | 1 | – | 4 |
| 9 Other Malformations | 7 | 6 | 1 | 2 | – | 5 | – | – |
| TOTALS | 100 | 88 | 12 | 19 | 8 | 55 | 1 | 17 |

* No follow-up required.

A closer look at the register shows that defects of the central nervous system occur most commonly and these defects, when they do occur, are associated with a very high mortality rate. There were 36 children notified during the year in this category and of these children 17 were still-born, 4 died in the first week of life and 1 child died before reaching 1 month of age, leaving only 14 children alive and well at 31st December. During the year ended 31st December, 1964 19 children in this category were notified and 5 only were alive and well at the end of the year. Children suffering from a major abnormality of the central nervous system are surviving in greater numbers than ever before due to the introduction of the Spritz Holter valve to control hydrocephalus and the continued development of surgical techniques for the treatment of spina bifida; these children in the main, however, are left with major permanent physical disabilities and we must think of the future. Will our services for the physically handicapped school child be adequate to ensure that each child receives an education at least as full and interesting as a child without a handicap? Looking even further ahead, what are the facilities for training and employment of the severely disabled? At the present time, Salford has no sheltered workshops for the severely disabled nor are there any training facilities within the City for school leavers so handicapped that they are confined to a wheelchair. It is true that in this technological age many firms operate training schemes and there are ample opportunities for young people to gain training in their chosen professions by attending training colleges and night schools, but for a chair-bound child, the problem of persuading an employer to employ a severely handicapped person pales into insignificance compared with the day to day problems of getting to work and travelling about the works' building up and down flights of stairs, even one or two steps, in a wheelchair. Even sedentary work, e.g. on a telephone switchboard becomes an impossibility if the toilets are not on the same floor as the switchboard. One must also think in terms of job satisfaction and future prospects of promotion. A physically handicapped teenager has as much right to enjoy his work and to look forward to promotion and increased responsibility as any other person. It would appear that the problem of the severely physically handicapped must be approached from two angles :–

(a) research into the causes and prevention of malformations of the central nervous system, and

(b) improvement in facilities to enable severely disabled persons to be fully integrated into all phases of normal life.

Criticism of the Register of Congenital Malformations remains as it was last year. The Registrar General is collecting information about malformations which are present at birth or are apparent within the first 4 to 8 weeks of life: this means that major malformations which are visually apparent are reported to the Registrar General but other malformations, possibly causing major disabilities, are under-reported because they are not identified until later in infancy and childhood. This must be borne in mind when studying figures based on notifications of congenital malformations under the present scheme.

### Appendix

In category 0 (Central Nervous System) 36 children were notified and these include 13 anencephalics, 5 hydrocephalics, 1 microcephalic, 11 infants

with varying degrees of spina bifida (3 of whom were also affected by skeletal abnormalities), 4 infants with both hydrocephalus and spina bifida (1 of whom also had skeletal abnormalities), 1 infant with anencephaly and spina bifida, and 1 infant with an occipito-cervical meningocele. Of the 14 children in this category who were alive and well at 31st December, 1965, 7 infants had spina bifida and 2 children had spina bifida and skeletal defects, 2 children had hydrocephalus, 1 child had hydrocephalus and spina bifida with other skeletal defects, 1 child had microcephaly and 1 child had an occipito-cervical meningocele.

In category 1 (Defects of Eye or Ear) there were only two notifications. One child was born with a malformed right pinna and the other child was born with a malformed right ear and a blind external auditory meatus (on examination by the Local Assistant Medical Officer this child was also found to have a blind left external auditory meatus).

In category 2 (Alimentary Tract), there were 5 notifications – 2 infants with hare lip and cleft palate, 1 infant with hare lip, 1 infant with cleft palate and 1 infant with an imperforate anus.

In category 3 (Heart and Great Vessels), there were two notifications, both of infants suffering from congenital heart disease, not further specified on the notification forms.

In category 4 (Respiratory System), there were 2 notifications – 1 infant with a displaced nasal system and 1 infant with laryngeal stenosis who lived only one day.

In category 5 (Urogenital System), there were 16 notifications – 10 infants had hypospadias, 1 infant had ectopia vesica and epispadias, 4 infants had other defects of the male genitalia and 1 infant was of interderminate sex (this infant died within half an hour of birth).

In category 6 (Limbs) there were 20 notifications – 9 children with talipes, 7 children with dislocation of the hip, 2 infants with syndactyly, 1 infant with a reduction deformity and 1 infant with another specified defect of the hand. In this category, 3 children were considered to have such trivial defects that no follow-up was required.

In category 7 (Other Skeletal Defects), there were 5 notifications – 3 infants with defects of the skull and face, one infant with arthrogryposis and 1 infant with achondroplasia and other foetal abnormalities. These two latter infants died during the first day of life.

In category 8 (Other Systems), there were 5 notifications –3 infants with defects of the skin, 1 infant with a birth mark in the lumbar region and 1 infant without hair, eyelashes or eyebrows.

In category 9 (Other Malformations) there were 7 notifications – 5 infants were diagnosed as Mongols (one of whom was still-born), 1 infant has mucoviscidosis, and 1 infant (still-born) had multiple abnormalities not specified.

## MEDICAL REPORT ON DAY NURSERIES

During the year a medical officer made 24 visits to the day nurseries as below :–

| | |
|---|---|
| Hayfield Terrace | 2 |
| Hulme Street | 1 |
| Bradshaw Street | 6 |
| Howard Street | 6 |
| Eccles Old Road | 4 |
| Private Day Nurseries | 5 |

Hayfield Terrace Nursery and Hulme Street Day Nursery were closed in April 1965 and the children from these nurseries were transferred to the remaining local authority nurseries, the mothers being given the opportunity to decide which of the three remaining nurseries they found most convenient.

The total number of individual children seen and examined at Local Authority nurseries was 247 (292 in 1964) and the total number of medical examinations carried out was 316 (398 in 1964). Of the 247 children seen and examined, 131 were new admissions during 1965.

All the children were found to be well and the number of physical defects noted was fewer than in previous years. The number of children requiring dental treatment was as low as 20, and the same number were found to have enlarged tonsils. On the treatment side 10 children were advised courses of Ultra-Violet Ray (Artificial Sunray) and 9 were recommended for courses of manipulative exercises. Only 7 children were classified as "unsatisfactory" at the time of their medical examination and on the whole the children appear to be healthier than in previous years. There have been no major outbreaks of disease amongst the children attending the day nurseries and there has only been one case of sonne dysentery during the year.

It has always been the practice to admit handicapped children to the day nurseries and during the year a Mongol boy, a little girl with a prosthesis on her right leg, and a mentally handicapped child have attended the nurseries: all these handicapped children fit happily into the nurseries and mix well with the other children.

The private day nursery listed above is owned by a rainwear manufacturer for the day care of the children of his employees and during the year the nursery was visited on 5 occasions. The number of children in the nursery has never at any time been more than 10 although the nursery is registered to take 17. The number of children examined at the five sessions was 3, 6, 4, 6 and 5 respectively, only one child being present in the nursery on all five occasions. All the children are healthy and appear happy; their mothers visit them at mid-day and give them their mid-day meals.

The children who attend the private playgroup at Cleveland House are not medically examined as the children only attend the group for three afternoons each week.

## REGISTRATION OF PRIVATE DAY NURSERIES

Under the provisions of the Nurseries and Child Minders Regulation Act 1948, the Local Health Authority is required to keep a register of premises which are used as private day nurseries.

At 31st December, 1965, there were three such premises registered with the Local Health Authority :–

(a) 4, Hilton Street, Salford, 7. These premises are owned and used as a private day nursery by a rainwear manufacturer to provide day care for the children of his employees.

(b) Cleveland House, Eccles Old Road. A pre-school playgroup run by a committee of mothers meets at Cleveland Clinic three afternoons per week. The Local Authority is not involved in the organisation of this playgroup, apart from renting the accommodation to the playgroup committee.

(c) 21, Wellington Street East, Salford, 7. On these premises, a day school for Orthodox Jewish girls under the age of 5 years is conducted.

In each case the premises are visited at regular intervals by members of the medical staff for the purpose of supervising the private nursery and the children who attend.

## PLAYGROUPS

It has become increasingly apparent that many Salford children are being deprived of an essential feature of their growing-up process because they have very few opportunities to mix with other children of the same age and to play. In the bad old days the children's playgrounds were the streets in which they lived but now in the era of the motor car and the multi-storey flats many young children are prisoners in their own homes and they are missing the normal experiences of childhood which are essential if they are to be sociable little people ready to mix with other children in the infant school.

In order to meet the needs of the children deprived of play facilities a number of experimental playgroups have been opened on clinic premises during the past nine months. At the present time there are four play centres :–

### (a) Ordsall Clinic

This group meets twice each week; there are 25 children on the register and no children on the waiting list. The average attendance is 15 children per session. There are no outdoor play facilities at this centre though there is a small piece of waste ground, fenced off, outside the clinic which belongs to the Health Department. It has been suggested that the boys from Ordsall Secondary School might be interested in clearing the site and grassing it over as a voluntary community project.

The children in this group are mainly in the "social problem" category, e.g. father working regular night work, but there are also a number of children in the group who are unable to play out of doors because of heavy traffic travelling to and from the docks.

**(b) Kersal Centre**

This group originally met twice weekly but the demand was so heavy that a third session was started. Attendance is limited to two sessions per week. The number of children on the register is 33 and there are 31 children on the waiting list. The average attendance is 22 children per session. There are outdoor play facilities available but the area is unfenced and the responsibility for so many children running about out of doors is too great for use to be made of the facility.

The children in this group come in the main from the multi-storey flats (66% of the children are in this category), but there is also a large group of children in the "social problem category" and in addition to this there are a number of handicapped children who attend the group regularly.

**(c) Summerville Clinic**

This group meets twice per week and there are 25 children on the register. The average attendance is 18.6 children per session, and outdoor play facilities are available in the grounds of the clinic. The demand for play facilities in this area of the City is high and there are 41 children on the waiting list. It is anticipated, however, that two private playgroups opening in the New Year in the Irlams o'th'Height area may help to meet this demand. The children who attend the centre belong in the main to the "social problem" category, e.g. overcrowded home conditions i.e. two families living in a two-up and two-down house, but in the main the demand for play facilities comes from parents who realise the advantages of teaching young children to mix with other young children at an early stage, before the children go into school.

**(d) Police Street Centre**

This group meets twice per week and the average attendance is 15.4 children per session. There are 25 children on the register and at 31st December there were no children on the waiting list. The only outdoor facilities available are the backyard, pram shelter and car park at the side of the premises. The area is covered only by soil and the sun rarely penetrates the gloom of the yard.

The children attending this group are drawn from the multi-storey flats and also from the "social problem" group in equal proportion with a small number of handicapped children and children in the other priority categories.

The playgroups all staffed by a Nursery Warden and a Nursery Assistant, both of whom were supernumery to establishment when Hulme Street Nursery and Hayfield Terrace Nursery were closed and the play equipment was also obtained from these nurseries at the same time.

The playgroups are intended to cater for the needs of children who are deprived of normal play facilities and these children can be divided into a number of categories :–

(i) Children from "problem families" or from families with problems. These constitute the "social problem" group and are frequently referred to the playgroups by Health Visitors or local authority Medical Officers,

(ii) Children living in high flats,

(iii) Handicapped children and children with speech defects or behaviour disorders,

(iv) "Only" children or children whose brothers and sisters are all at school,

(v) Children whose mothers are occupied caring for new babies or sick or elderly relatives,

(vi) Children whose mothers are in poor health and who need periods of rest in the interests of their own health.

The play facilities offered include sand and water play, painting, dressing-up, modelling in clay, cutting out and pasting, story telling, Wendy House, and toy shop and musical games. The equipment necessary for these activities is not expensive but in view of the large numbers using it, requires frequent replacement.

At the present time no charge is made and no refreshments are supplied as the playgroups meet for only two hours each session.

There is no doubt that the playgroups are serving a very useful function and they are greatly appreciated both by the children who attend and by their parents and it is very much to be hoped that we may be able to extend our activities in this field in the near future.

## PHYSIOTHERAPY

During the year the physiotherapy section has widened its scope in two fields, namely that of Mental Health and the rehabilitation of handicapped and elderly people in their own homes, in co-operation with the home nursing service. This work has been carried out without any increase in the number of physiotherapists.

Many physiotherapists are at first apprehensive when commencing work with the mentally handicapped because, until recently, so little work had been done that it has been difficult to determine how beneficial the treatment might be. Physiotherapy has now been given in this City for a sufficient length of time for us to see that the mentally handicapped obtain great benefit from such treatment. Groups of mental health workers from other areas who have visited our centres have all been extremely interested in the physiotherapy treatment and many have said how anxious they are to arrange this treatment at their own centres.

Some of the children in the Special Care Unit at Wilmur Avenue Centre may be both mentally and physically handicapped and if left untreated would develop gross deformities necause of their inability to move their limbs and bodies. The staff at the Special Care Unit co-operate fully with the physiotherapists in helping the children to increase their activities and in changing the children's positions so that deformities and contractures do not develop. Many of the children, because they are not very active or are mongols frequently suffer from chest infections, and because of the difficulty they

have in coughing up sputum they require help either in the form of drainage of their chests or of treatment to loosen the sputum. During the winter months the children were given two courses of artificial sunlight treatment and this helped to build up their general health and resistance to infection.

At the Seedley Junior Training Centre as well as routine physiotherapy, a physiotherapist and some of the centre staff have taken a small number of children to a roller skating rink which they have very much enjoyed, and some children have shown remarkable proficiency. The weekly visit to the small, warmed swimming bath at Blackfriars Road has also helped relaxation and given pleasure to many of the children.

The accommodation at the Crescent Adult Centre is so limited that treatment and any form of activity is very restricted. Physical handicaps are treated by the physiotherapists as well as possible under difficult circumstances. Many of those attending the centre would benefit from a programme of organised activities and ball games out of doors.

The young handicapped child is given physiotherapy treatment at the nearest clinic to his home. The younger the baby is when treatment commences the greater the chance of the child developing all the muscles it may have, and the less the chance of developing deformities in later life. The mother of a handicapped child needs much support from the first time she realises the child is different from other babies, and if the mother is taught how to help her child it gives her a positive function and lessens her bewilderment.

Children under five years of age often have minor orthopaedic deformities of the feet and legs. Usually these are a stage in the child's development and slight bow leg and knock knee deformities often correct themselves by the time the child reaches school age. However, in some children these deformities persist, and these are particularly noticeable when so many teenage girls are wearing the "mini" skirt. These legs are not always very pretty and it is well worth treating babies and young children who appear to be developing such defects.

Ante-natal relaxation classes are appreciated and enjoyed by the many young mothers who attend. More articles are now being written in daily newspapers and women's magazines on preparation for childbirth, and the young mother having her first baby is greatly interested in preparing for the actual birth and in strengthening her muscles and regaining her figure after the birth of her baby.

Unfortunately, the girls we would most like to help and who need preparation for an event of which they have little real knowledge do not come to these classes, often because they do not even attend the ante-natal clinics until late in pregnancy.

A physiotherapist has commenced to make fortnightly visits to the Salvation Army Home for unmarried mothers. The authorities have been very co-operative, and the girls appear to be interested in the classes and ask many questions afterwards.

The physiotherapy clinics run in conjunction with the Geriatric Clinic at Langworthy Road have become busier during the year. The regular weekly

treatments help to keep the elderly people active and though we do not wish to carry out those treatments which should properly be done in the hospital there is a great need for these clinics away from the hospital atmosphere, where rheumatic pains can be alleviated by heat treatment and tight bronchitic chests helped by breathing exercises. The social aspect of these clinics is very great; interest is awakened in making the effort to wash and dress and get out of the house and at the clinics there are other people happy to converse over a cup of tea. Only the hardest hearted person could ever discharge these people to whom a little interest taken in them means so much.

During the year there has been increased co-operation with the Home Nursing Section in an effort to rehabilitate handicapped people in their homes and to prevent them becoming bed-ridden helpless cripples. Again we are not aiming to do the hospital's work, but patients carrying out exercises in the gymnasium of a hospital have many difficulties when they come to do these exercises in the cramped conditions of the home. The physiotherapist visiting the home can help the relatives to re-arrange furniture and to show them the best way of lifting to prevent strained backs both for themselves and the patient and to adapt simple gadgets which will make everyday living easier.

We have explained to general practitioners that we are unable to provide a three times a week "rubbing service" but we are very willing to co-operate in rehabilitation and the doctors have been most helpful.

There have been a small number of occasions when it has been felt that we were asking too much of a heavily burdened mother to bring a badly handicapped child to a clinic for treatment. An example is of a family living in a multi-storey block of flats, where there are seven children and a two-year-old seriously handicapped child; the child could not even sit up and at first the mother had no large perambulator. Twice weekly physiotherapy was given at home for three months, a large pram has been provided and the child has progressed sufficiently to enjoy being taken out to the clinic in fine weather.

We know that without co-operation from the other sections of the health service we could not carry out our work to help as many people as possible and we are fortunate that the heads of sections and their staff are most helpful, for which we are most grateful.

# FAMILY GUIDANCE CLINIC

In the past year, a wider concept of Family Guidance has been practised. There has been a reduction of whole sessions devoted to this work to once fortnightly, but a parent or child involved in family disturbance has been promptly seen through the agency of the routine child health clinic wherever this is practicable. The numbers seen at that particular session are then always adapted accordingly to allow sufficient time for the problem to be fully investigated. The advantage of this is that as the system is more flexible more can be seen, and at the most convenient clinic. Also, parents and children who baulk at any mention of child or family guidance co-operate more readily when they think they are attending a routine welfare clinic.

Again, time wastage due to failed appointments which is harder to organise with a smaller clinic can be reduced to a minimum when greater numbers are invited, as occurs in a "mixed" session of both problem and routine work.

In the course of family guidance therapy one factor stands out increasingly. This is that when the parental limitations are great – either through lack of intelligence or sufficiently strong emotional motivation – to effect much improvement in the parent – child relationship, the children themselves are having to be strongly helped and encouraged to improve standards of behaviour through their own sense of awareness to responsibility. It is heartwarming on occasions to see how such children do respond to this situation, and begin to realise that their parents are also subject to human frailties and are not unfeeling machines in the background to attend to material comforts and to be taken for granted.

Teachers continue to welcome the degree of interest taken in the child and family where disturbance is manifest and provide much useful information to which the health visitor often makes a large contribution. A most cordial liaison is maintained with both services which is greatly appreciated. Finally, increasing numbers of family doctors utilise our help in this field, confident of the time and sustained interest that will be given which they are unable to provide, however willing, through pressure of numbers attending over-sized surgeries.

The Family Guidance Service has made a well-recognised place for itself in the hierarchy of the Health Department and in the coming years it is hoped to co-opt more doctors from the staff into this important work.

# CONVALESCENCE

Eleven applications (4 children and 7 adults) were received, plus a number of requests regarding citizens over pensionable age who were referred to the Civic Welfare for inclusion in arrangements made especially for their age group.

Of the 11 applicants, 6 were women (one with 3 children) 1 child alone and 1 man.

Three of the women were referred to the Civic Welfare Department for placing at Southport because they suffered from bronchitis; one was assisted through the Cotton Districts Convalescent Fund for a stay at St. Annes; the mother with 3 children was to have been assisted by the local authority to stay at Grey Court but she did not wish to disturb commitments she had locally so did not take up the offer. We were unable to place the sixth woman because of her particular disability.

The mother applied for convalescence in respect of the child alone, but it was considered that continuous care rather than a short period of convalescence would be more beneficial and he was placed in a day nursery free of charge in view of his condition and home circumstances.

The one man who applied was placed at St. Annes with assistance from the Cotton Districts Convalescent Fund.

# GERIATRIC GUIDANCE SERVICE

During the year the number of health check-ups for elderly people was increased to three a week. The clinics at Langworthy Centre were continued and additional sessions were started at Regent Road Clinic.

At these clinics old people can discuss their problems at length with a medical officer, who also carries out a thorough medical examination.

Chiropody treatment, available on the premises, often provides great relief for the old people.

Physiotherapy treatment continues to be of great benefit to many of those who attend the clinics. Those with fibrositis or arthritis often find that radiant heat and massage given weekly will relieve their pains considerably, increase the range of movement in their joints, and enable them to participate in ordinary activities. Some of them have said that but for physiotherapy treatment they would no longer be able to walk. Those with chronic bronchitis — an all too common condition in elderly persons in Salford — find that breathing exercises and postural drainage relieve the severity and the frequency of their coughs.

Ill-fitting dentures are frequently found, but here the problem is often that the patient realises new dentures are needed but cannot afford to pay for them.

Those whose diet is inadequate or who are anaemic continue to be helped by vitamin supplements or iron tablets.

Serious medical conditions such as retraction of the nipple, abdominal masses, rectal bleeding or marked herniae are sometimes found on examination. The patient is then referred to a specialist either through the family doctor or directly (after obtaining the family doctor's consent).

A total of 48 women attended Langworthy Centre, the average number of attendances each being two. Some attended as many as five times. 23 women attended Regent Road Clinic, each of them coming once.

A total of 34 men attended Langworthy Centre, the average number of attendances each being, again, two, with some coming as many as four times. At Regent Road Clinic 49 men attended, some of them coming once, and about half of them coming twice during the year.

Of the 48 women who attended Langworthy Centre during the year, eleven (23%) had gynaecological complaints or were found to have gynaecological defects. Two women complained of stress incontinence and three of pruritus vulvae. Two had thrombosed external piles, one had ballooning of the rectum and anal skin tags, one had intertrigo of the perinium and anal fold, and two were found to have a prolapse.

# INCIDENCE OF BLINDNESS

A1. Registered Blind Persons

A2. Registered Partially Sighted Persons

B. Ophthalmia Neonatorum.

Blind Person

## A1. FOLLOW-UP OF REGISTERED BLIND PERSONS

Total number of cases registered during 1965.....48

| (i) Number of cases registered during the year in respect of which Section F.(1)of Forms B.D.8 recommends:— | Cause of Disability | | | |
|---|---|---|---|---|
| | Cataract | Glaucoma | Retrolental Fibroplasia | Others |
| (a) No treatment | 9 | 4 | — | 25 |
| (b) Treatment:— | | | | |
| Medical | — | — | — | — |
| Surgical | 5 | 1 | — | — |
| Optical | — | 1 | — | — |
| Ophthalmic Medical Supervision | 1 | 2 | — | — |
| (ii) Number of cases at (i) (b) above which, on follow-up action, have received treatment | 3 | 3 | — | — |

## A2. FOLLOW-UP OF REGISTERED PARTIALLY SIGHTED PERSONS

Total number of cases registered during 1965.....18

| (i) Number of cases registered during the year in respect of which Section F. (1) of Forms B.D.8 recommends:— | Cause of Disability | | | |
|---|---|---|---|---|
| | Cataract | Glaucoma | Retrolental Fibroplasia | Others |
| (a) No Treatment | 1 | — | — | 7 |
| (b) Treatment:— | | | | |
| Medical | — | — | — | — |
| Surgical | — | — | — | — |
| Optical | — | — | — | — |
| Opthalmic Medical Supervision | 2 | 2 | — | 6 |
| (ii) Number of cases at (i) (b) above which, on follow-up action, have received treatment | 2 | 2 | — | 6 |

## B. OPHTHALMIA NEONATORUM

| | |
|---|---|
| (i) Total number of cases notified during the year | Nil |
| (ii) Number of cases in which:— | |
| (a) Vision lost | Nil |
| (b) Vision impaired | Nil |
| (c) Treatment continuing at end of year | Nil |

# HEALTH VISITING SERVICE

The Health Visiting Service continued to cover a wide range of duties, including combined general health visiting/school nursing/tuberculosis visiting; specilists services for the aged, socially handicapped families, and hospital liaison; health education; domiciliary immunisation; domiciliary bathing and foot hygiene for the elderly; and the practical training of students of various kinds. The demands on the service were increased still further by the visiting of notified imigrants; the extension of clinic activities and screening techniques; the need for setting up special clinics for polio immunisation during the summer months when there was an outbreak of poliomyelitis in a neighbouring town; by participation in surveys at both local and national level; and an increase in health education.

The health visitor is traditionally associated with research projects by virtue of her unique position of being in touch with more people of varied kinds than any other worker engaged in aspects of social work, and she has assisted in many notable projects in the past including that which was concerned with the relationship of rubella in pregnancy to congenital malformations. It was not surprising, therefore, that Dr. Komrower, Consultant at the Royal Manchester Children's Hospital, asked for the assistance of health visitors in relation to The Happy Family Survey which he is conducting, and which is aimed at detecting metabolic disorders associated with mental retardation at an age when early treatment can be initiated. This has involved obtaining the co-operation of the parents and the taking of a sample of blood from the heel of the baby by the health visitors. From the start of the survey in October to the end of the year 654 blood samples had been taken. It is greatly to the credit of the health visitors that in spite of some unresolved staffing difficulties they faced this extra work with equanimity.

### Staffing

It was not possible to recruit enough health visitors to complete the establishment, and a more realistic approach to this problem seems necessary. The health visiting service is extended to thousands of people, and the nature of the work in industrial areas is very much more difficult than that in pleasant rural areas. Though it is true that working in a City such as ours presents a challenge which some are prepared to accept and even enjoy, it has to be appreciated that a sufficient number of such people cannot be attracted to meet the needs of the service and some other incentive such as an industrial loading or bonus is probably the only answer to staff shortages. To imagine that health visitors are clamouring to do the more difficult work in cities which contain greater numbers of socially handicapped persons, is to put ones head in the sand at a time when now, as never before, there is a wide variety of choice for girls embarking on a career.

Five student health visitors were successful in examinations and joined the staff in July. A male health visiting officer completed a course of training in Aberdeen at the same time. The appointment of a male student was a new venture which has every indication of being successful. It would seem that the public will accept males in this situation as readily as they have been accepted in nursing, medical and social work fields for many years.

Two health visitors were appointed as Field Work Instructors and attended an appropriate course of training before taking up their duties.

At the end of the year the total staff numbered 73, of whom 53 were professionally qualified workers and 20 were nursing auxiliaries. In addition, 5 student health visitors were undergoing training.

## SPECIALIST HEALTH VISITOR SERVICES

### (I) HOSPITAL LIAISON

This was extended to include the Royal Manchester Children's Hospital. During the year 2,424 messages were relayed to health visitors with appropriate follow up and return of information to the staff of the various hospitals.

#### (a) Hope Hospital

The liaison here was predominantly with the Paediatric Unit, the aim being to convey information between health visitors and hospital staff as speedily as possible. Liaison with the Orthopaedic Department increased during the year. The staff of the children's surgical wards were conscious of the part the health visitor can play when the children are discharged home, and special instructions were given for continued care. Much time was spent ensuring that all defaulters from the Neo-Natal Clinic were traced and encouraged to keep up appointments. Very often the babies involved are those 'at risk' and in the child's interests it is important that they should not be 'lost', as clinical discussion, further assessment, and treatment may be necessary. Close contact was maintained at all times with the medical social workers, especially in relation to the children of unmarried mothers and the after-care of premature infants.

#### (b) Ladywell Hospital

In this instance only two wards were visited; those accommodating children suffering from infectious diseases. A weekly visit was paid, and further contact maintained as the occasion demanded.

#### (c) Royal Manchester Children's Hospital

A request was made early in the year for the health visitor liaison scheme to be extended to this hospital, and two visits a week are now made. Several of the consultants extended an invitation to the health visitor to be present during ward rounds; however, it was quickly realised that at this particular hospital the number of Salford children on the wards at any one time was small, so this proposal was discarded in favour of one which is more economical of the health visitor's time, viz. a visit to the wards for discussion of cases with the ward sisters.

A greater number of children were found to be presenting problems at the Out-Patient Department, and at the invitation of the medico-social Worker, a weekly visit to the O.P.D. was started in April.

### (d) Diabetic Clinics

#### (i) Salford Royal Hospital

Gradually the pattern here has changed. The patients themselves now recognise the role of health visitor in the clinic and request to see her to ask advice about their diabetic and other problems. Many queries were dealt with expediently in this way.

The number of elderly persons with controlled diabetes increased and information concerning their general health, treatment, etc. was transmitted to the health visitor with special responsibilities for the elderly; conversely elderly patients found to be unstable were referred for further help and advice.

#### (ii) Hope Hospital

In the absence of a dietician, new diabetic patients were referred to the health visitor for instruction in the management of diet; the initial information being given at the clinic, with subsequent home follow-up. Visits were made to the spouse or person responsible for the care of elderly relatives. This has been greatly appreciated, as many wives take a keen interest in the preparation of a diet and have a desire to provide variety. Visits to diabetic patients attending hospitals outside the group were only made if requested.

The following information relates to the diabetics of both hospitals :–

| | |
|---|---|
| New patients referred | 54 |
| Number of patients visited | 82 |
| Number of visits paid | 213 |

### (2) CHEST CLINIC LIAISON

Though the number of notified cases of Tuberculosis continued to fall, the patients presented more problems and difficulties than in the previous year. To some extent this was due to an increasing awareness of the function of the liaison health visitor, who had 200 personal interviews with patients throughout the year. She also devoted a great deal of her time to contact tracing and the visiting of clinic defaulters. 4 cases of tuberculosis were found among the contacts examined. The number of young children receiving B.C.G. vaccination increased; a good number of these were done through encouragement of the parents by health visitors, others were at the request of the parents themselves.

| | |
|---|---|
| Number of notifications of Tuberculosis | 45 |
| Number of transfers | 15 |
| Number of Mantoux Tests | 380 |
| Number of B.C.G. Vaccinations | 305 |

**Thoracic Surgery, Lung Cancer, Bronchitis and other chest diseases**

The liaison health visitor was able to supply useful information concerning the family background to a consultant thoracic surgeon and the chest physicians who met monthly at special sessions held at Ladywell Hospital. She was also able to assist with health education particularly in relation to smoking,, and was able to encourage some patients to attend the anti-smoking clinic held weekly in the Health Department. Follow-up visits were made to assist with post-surgery re-habilitation and supportive therapy.

## (3) CARE OF THE ELDERLY

The Specialist Health Visitor was assisted by a team of S.R.N.'s as in previous years, and for the first time had a male health visiting officer to work with her on a sessional basis.

Every person referred was visited as soon as possible after referral, priority being given to those living alone, so that domiciliary services were laid on with a minimum of delay. The majority of those in the most vulnerable group, i.e. those alone, the very old, and very frail had a multiplicity of help, including the services of the home help, and the nursing auxiliary for bathing or foot hygiene services.

**Liaison with other services**

Every effort was made to maintain the morale of the elderly people and to provide the maximum amount of help and to this end considerable liaison with other services and voluntary organisations was necessary. The Civic Welfare staff were particularly helpful especially in relation to admissions to Part III accommodation; holidays; visitors for the blind and deaf elderly; and the provision of items of furniture and bedding. The Cripples Help Society visited the physically handicapped aged referred to them and assisted by the loan of equipment of many kinds, in addition to arranging for suitable persons to attend clubs and outings organised by the society. The provision of transport where required was a great help. The W.V.S. gave assistance as before in relation to meals on wheels and clothing and kept a watchful eye on the old ladies living in the W.V.S. flatlets, referring those giving cause for concern to the Specialist Health Visitor.

The Specialist Health Visitor continued to receive help from Booths Charity which provides flat accommodation for 200 elderly people and from whom 1,200 elderly persons receive 10/- per week; a useful extra over and above the supplementary pension, with which to obtain extra comforts. The Specialist Health Visitor worked closely with National Assistance Officers who were most helpful when approached for help.

A number of cases, too large to enumerate, were referred to agencies concerned with the welfare of old persons.

The number of persons referred to the section was 990 (693 females and 297 males), slightly lower than the previous year. 4,643 were transferred from the year before, making a total of 5,633 cases; an increase on the preceding year in the overall number of cases receiving attention. There was a sharp increase in the number of bed-ridden patients referred.

Particulars of distribution, age, sex and type of referrals are given in the following tables :–

**Distribution of cases**

| Ward | New Cases 1965 | Old Cases | Total |
|---|---|---|---|
| Albert Park | 93 | 365 | 458 |
| Charlestown | 59 | 320 | 379 |
| Claremont | 105 | 348 | 453 |
| Crescent | 23 | 136 | 159 |
| Docks | 55 | 254 | 309 |
| Kersal | 64 | 361 | 425 |
| Langworthy | 70 | 427 | 497 |
| Mandley Park | 88 | 400 | 488 |
| Ordsall Park | 47 | 252 | 299 |
| Regent | 102 | 520 | 622 |
| St. Matthias | 14 | 143 | 157 |
| St. Paul's | 61 | 217 | 278 |
| St. Thomas's | 29 | 130 | 159 |
| Seedley | 73 | 332 | 405 |
| Trinity | 42 | 163 | 205 |
| Weaste | 65 | 275 | 340 |
| Total new cases | 990 | Total old cases 4,643 | Grand Total 5,633 |

**Age Group**

| | |
|---|---|
| 60 – 64 years | 202 |
| 65 – 69 years | 203 |
| 70 – 74 years | 216 |
| 75 – 79 years | 136 |
| 80 – 84 years | 121 |
| 85 – 89 years | 47 |
| 90 + | 9 |
| Under 60 years (handicapped) | 56 |
| | 990 |

**State of Activity**

| | |
|---|---|
| Bed-ridden | 337 |
| House-bound | 351 |
| Semi-ambulant | 122 |
| Ambulant | 180 |
| | 990 |

**Sources of referral**

| | |
|---|---|
| Civic Welfare | 59 |
| Found in the course of visiting | 96 |
| Family Doctors | 90 |
| Health Visitors | 49 |
| Home Help Section | 31 |
| Hospitals | 139 |
| Mental Health Section | 13 |
| Relatives and friends | 338 |
| Public Health Inspectors | 9 |
| Voluntary Organisations | 21 |
| Housing Department | 79 |
| Other statutory agencies, e.g. District Nurses | 66 |
| | 990 |

**Reasons for referral**

| | |
|---|---|
| Alone and neglected | 10 |
| Cancer | 48 |
| Chest complaints | 90 |
| Diabetes | 49 |
| Nephritis or other kidney diseases | 5 |
| Rheumatism | 119 |
| Senile demention and allied conditions | 52 |
| Vascular disease | 54 |
| Cardiac disease | 73 |
| Nervous diseases | 16 |
| Blind | 9 |
| Deaf | 13 |
| Miscellaneous complaints | 237 |
| General advice | 105 |
| Chiropody | 110 |
| | 990 |

**The Elderly living in Flats**

There is growing evidence that rehousing into flats has an adverse effect on the mental health of those concerned. Some of the flats such as those with only 4 flats to a central landing can be very lonely places in which to live, the neighbours being rarely seen. Although the caretakers are considerate and show interest in the old people living alone, there seems to be a need for flats of a special kind for the elderly with the provision of a warden-caretaker who, working closely with the statutory agencies concerned, could notify those who were seen to be deteriorating in health or to be in need, and could promote social activities within the group.

**Bathing Service**

The demands on this service were heavy and at times there was difficulty in meeting requests – due to other calls upon the nursing auxiliaries' time. The nursing auxiliaries coped admirably under some of the most difficult

conditions in homes where the facilities for bathing were practically non-existent. In some cases it was necessary to lend a plastic bowl from the Department if the one and only bowl in the house was used for other purposes, such as washing-up and cleaning, and more insanitary purposes. Wherever possible the same nursing auxiliary attended her own cases, since elderly people resent change, are essentially modest, and tend to make feeble excuses for not being bathed when faced by a stranger.

### Foot Hygiene

This service which has proved its value in the greater comfort and increased mobility of the patient, continued as before. In many cases the treatment was given at the request of the chiropodist and took place between chiropody treatments.

### Hospital admission of the elderly

At the end of the year there was a long waiting list of patients for hospital admission, some of whom were psycho-geriatric patients. Such patients are a cause of worry and anxiety to their neighbours and relatives alike who are at a loss to deal with the situation. These patients present a real safety risk. Cleveland House provided good day care for quite a number of this group, and undoubtedly could play a greater role if sufficient transport were available.

### Family Doctors

The health visitors attached to general practices co-operated fully with the Specialist Health Visitor for the elderly so that there was no duplication of visiting. In most instances the cases referred by the family doctors were already known to the elderly section, and had already received help. Throughout the year, there was an increase in number of visits requested by family doctors.

### Elderly Persons Fund

Through this Fund it was possible to help 49 people with a number of requirements, including walking sticks, fireguards, kitchen utensils, cleaning materials, fuel, food and nourishing drinks and in one case a gift of flowers to celebrate a 90th birthday.

## (4) SOCIALLY HANDICAPPED FAMILIES (Prevention of Family Break-up)

At the end of the year the number of families on the problem family register numbered 247, and 255 families were listed as potential problem families.

The Specialist Health Visitor worked closely with the staff of the Children's Department, National Assistance Board, and N.S.P.C.C.; with School Welfare Officers, Probation Officers, Prison Welfare Officers, the Family Service Unit, and numerous other voluntary and statutory workers. She also discussed aspects of care and referral with the area health visitors, conducting a number of individual discussions each day, and undertook intensive visiting on behalf of 6 families so that it was possible to give the time and support required. In addition, 291 home visits were made throughout the year.

**Office Consultations**

In addition to the interviews granted to those referred by family doctors and social workers, members of the public request advice from the Health Visiting Service about problems of a medical, social, or personal nature, and such persons are usually seen by the Specialist Health Visitor in the first instance. During the year, 196 self-referrals were made and are summarised below :–

| | |
|---|---|
| Marital problems | 44 |
| Ill Health | 10 |
| Help re clothing | 20 |
| Care of children | 10 |
| Financial difficulties | 13 |
| Mental Illness | 5 |
| Ill treatment and neglect | 10 |
| Disconnection of gas or electricity | 17 |
| Housing and accommodation problems | 35 |
| Threatened eviction | 10 |
| Ante-natal problems | 12 |
| Miscellaneous help | 10 |

**Case Conference**

Case conferences arranged by the Children's Officer were attended regularly.

**Homeless Families**

13 families were admitted to Part III accommodation, involving 37 children ; none of these was known to the health visitor prior to eviction ; all were of the nomadic type of family.

**Prisoners' Families**

The liaison with the welfare officers at Strangeways prison continued. 40 families were notified and visited in 1965. In some instances the family was already well known to the area health visitor; where this was not the case the family was visited initially by the Specialist Health Visitor and 13 such families required regular visits and help until the husband was discharged from prison and in employment. These families are especially vulnerable and often require a great deal of support to enable them to adjust to the separation from husband and father and in some cases to a reduction in income.

**Day Training Centre**

The centre has continued to provide for a small number of mothers and children with special needs. In a friendly, informal manner the domestic science teacher responsible for the teaching of simple household tasks has encouraged her small group of inadequate mothers to achieve some success in the performance of domestic skills. One young mother, on probation for shop-lifting, was referred to the centre by the probation officer ; her husband had only just completed a prison sentence for larceny. She had very little knowledge of housekeeping and budgeting. At first it appeared that she would

have a disrupting influence on the group; however, through an example of patience and understanding she has now settled down and enjoys the activities and in addition to doing cookery and sewing is now knitting a suit for her child.

One of the interesting features of the centre is the help which can be given to the children of the mothers who attend. A room is set aside for the children in which they can play under the supervision of a nursing auxiliary, who is encouraged to promote play activity of an educational nature and to encourage the children in the formation of good habits without rigid disciplines. The children respond extremely well in this atmosphere, and some children who were cowering and withdrawn on admission are now socially adjusted.

Unfortunately, it has not been found possible to overcome the problem of getting some mothers, who need the help which a centre of this type can afford, to attend. It is inevitable that the inadequate mother will feel that the effort of getting herself and the children ready and making a journey by public transport is too much. It had been hoped that voluntary helpers would assist in this matter, but unfortunately no organisation has been able to accept the job of calling at the homes to collect the mothers. The Specialist Health Visitor has conveyed some mothers and children in her own car, knowing that once having been introduced to the centre some mothers would continue through their own efforts to attend; however, there is need for an organised system of collection and if this cannot be achieved through voluntary channels possibly the answer lies in the provision of official transport.

Valuable though the acquisition of domestic skills may be, perhaps the most important aspect of the Day Training Centre is the opportunity it provides for social contact. The mothers attending are often ostracised by their neighbours because they fall short of the accepted standards of the neighbourhood from which they come, and in some cases they withdraw from social contact because of the inadequacy of their homes, and the need to hide from others the bad personal relationships existing within the home. Under such circumstances the family tends to deteriorate still further. At the Day Training Centre such difficulties are understood and shared.

## TRAINING OF STUDENTS

With the appointment in September of an Assistant Superintendent Health Visitor with special responsibilities, it was possible to restore the arrangements of previous years which allowed hospital and other students to gain an insight into the work of the Health Department, which is necessary not only for the student to obtain information for examination purposes, but for the promotion of a deeper understanding of the patient's home environment and the difficulties to be faced within the community. During the period September – 31st December, lectures and visits of observation were arranged on behalf of the following students:-

| | |
|---|---|
| Student Nurses (Hospital) | 45 |
| Nursery Nurses | 12 |
| University of Manchester Community Nursing Course | 8 |
| Health visitor student from a county area (requiring experience of an industrial area) | 1 |

**Post-graduate students**

| | |
|---|---|
| Social administration | 4 |
| Royal College of Nursing | 1 |

**Diploma in Child Health** 1

**Student Health Visitors**

The practical training of sponsored student health visitors for the course commencing September, was for the first time arranged and supervised by the newly appointed field-work instructors who worked closely with the tutors of the training centre. Regular discussions were held with the students.

## IN-SERVICE TRAINING

New clinic nurses and nursing auxiliaries were each given a two-week in-service training before taking up duties in the home, clinic and schools.

In-service training for established members of the staff was provided as follows :—

**Screening tests of hearing**

A one day lecture/demonstration course was given by Professor Taylor in the distraction test used for testing young babies. 20 members of the staff attended.

**Central Council for Health Education**

This body organised a three day course which was attended by 27 health visitors and 9 clinic nurses. The subjects covered were Advanced Techniques in Health Education; Men and Women in Middle Age; Human Relations in Society the Family and Schools, and Medical Aspects of Health Education in Schools. Staff from other authorities also attended this course.

**Child Psychiatry — discussion group**

Those members of the staff who had not been able to participate in these discussions in the previous year attended this group, thus completing the series.

**Paediatrics**

The Consultant Paediatrician from Hope Hospital continued his series of talks at fortnightly intervals during the first six months of the year. A new series in which the emphasis is on the role which the health visitor can play in relation to early detection of deviation from the normal in the young infant, began late in the year and will continue until all health visitors have attended a course

**Mental Health**

As a means of acquiring greater insight into mental health problems, and

to further liaison between the two sections, two health visitors at one time have attended the monthly case conference held in the Mental Health Section, on four occasions. This will continue until all health visitors have had an opportunity to attend.

### Refresher Courses

Two health visitors attended a two week course on Health Education at Homerton College. The annual refresher course organised by Manchester Health Department, which had as its subject 'The Child at Risk' was attended by 13 health visitors.

## HEALTH EDUCATION

Every opportunity was seized to extend health teaching in the home, school, hospital and clinic. Health visitors participated in in-service training schemes arranged for home helps by giving lectures at five sessions on specialised aspects of the health visitors work, and met the requests for talks to outside organisation.

### (a) Toddlers' Clubs

Most mothers worry about the behaviour and development of their children, at least for some of the time, if not all the time, so as a vehicle for health education, toddlers' clubs were formed at two of the centres in September. The object of the clubs is to provide an opportunity for mothers of children between 2–5 years to meet together, at fortnightly intervals, to discuss topics of mutual interest with the health visitor. From the outset it was decided that no physical examinations should take place and that an informal atmosphere would prevail in which the mother felt at ease to enter discussion. At the end of the year the clubs were being well attended. Topics have been varied and films have been used to promote discussion. Provision is made for the minding of the children by the use of voluntary helpers from The League of Jewish Women.

### (b) Salford House

In the autumn the newly appointed Male Health Visiting Officer began weekly visiting of this establishment which has accommodation for 285 men. 54% are over 65 years of age and need special supervision and many of the residents need some guidance in matters of nutrition and hygiene. Health education in such a setting will be a great challenge, but it is undoubtedly worth the attempt.

### (c) Hope Hospital

Talks to groups of post-natal mothers on the hospital wards have continued. Health visitors have given 4 talks a week in which such subjects as normal development and milestones, emotional needs, home safety and social services were dealt with. The mothers showed particular interest in the participation flannelgraph "Emotional Needs".

## UNMARRIED MOTHERS

Close co-operation was maintained throughout the year with medico-social workers at the hospitals and the social workers attached to Moral Welfare Organisations, to ensure that adequate arrangements were made for the care of the unmarried mother and her child. Financial grants were made in respect of hostel accommodation for 24 Salford girls and per capita grants for outdoor casework were paid in respect of 79 girls.

The Assistant Superintendent Health Visitor, appointed in September, dealt with office interviews and inquiries made after her appointment and will be responsible for the co-ordination of this work in future and will act in an advisory capacity to district health visitors.

## EXPANSION OF CHILD WELFARE CENTRE ACTIVITIES

In previous years two centres have undertaken screening tests of hearing, but after a training session in January, screening tests were made available at all the centres, for children under one year. Tests for the older groups were made at Langworthy and Kersal Centres as in the past. Health visitors are responsible for the actual test but with the approval of Professor Taylor and after participation in the training scheme, nursing auxiliaries have been employed at these sessions to distract the baby, a not unimportant role since accurate testing is dependent on correct distraction of the child.

The results of these tests are as follows :—

| | |
|---|---|
| Number who passed at 1st test | 928 |
| Number who required 2nd test with subsequent pass | 132 |
| Number referred to University Audiology Clinic | 13 |

Of those referred to the University the results were as follows :—

1 child has results suggesting high frequency deafness :—
to be re-examined later
1 child was found to be partially deaf
1 child was referred for surgery
2 children are still under the supervision of the audiology clinic
1 child was discharged—failure was thought to be due to immaturity
1 child—results not yet received
6 children are awaiting appointments

## HEALTH CHECK-UP

Clinic nurses and nursing auxiliaries staffed 47 sessions at the annual major health check-up, which was attended by 3,201 people during the six weeks period, in addition to staffing the regular sessions at Regent Clinic, and were responsible for registering weights and heights, taking blood pressures, testing visions and estimating haemoglobins. It was also necessary to offer polio immunisation facilities during this period because of an outbreak of poliomyelitis in a neighbouring town, and in all 10,740 doses of polio vaccine were given.

### Road Safety Campaign

The section co-operated with the campaign organised by the local police force in April, by providing nursing auxiliaries to test the vision of drivers with the Keystone vision screener, for a two week period.

## HEALTH VISITORS – FAMILY DOCTORS

Liaison between family doctors and health visitors continued as in former years; for the most part this consisted of a weekly visit to the surgery with an exchange of information on both sides, and telephone contact as necessary. During the year two health visitors were attached to group practices, visiting the surgery daily and visiting patients of the practice without geographical boundaries for an experimental period. A third health visitor extended her weekly liaison to daily visits to the surgery, to visiting patients of the practice in any part of Salford without retaining the families permanently. It was found that it was possible to visit the doctors' patients in any part of the City provided the health visitor was mobile and the number of daily referrals was small. It was necessary for the health visitors concerned to remain responsible for their own district since so many of the people already visited by them were outside any attachment schemes, and no extra staff was available to relieve them of this work. While the number of daily referrals from the family doctors is relatively small the arrangement described works well, but one can foresee a time when the doctor will refer more and more work to the health visitor and a different system would have to be considered.

## STATISTICS

A statistical summary of visits paid and clinics attended by all members of the staff of the Health Visiting Section is given below.

### Health Visitors and Clinic Nurses

| Type of Visit | Access | No Access |
|---|---|---|
| Visits to children 1 – 5 years | 33,738 | |
| Visits to aged persons | 7,640 | |
| Visits to tuberculous patients | 751 | |
| Visits to expectant mothers | 521 | |
| Hospital follow-up visits | 60 | |
| Mental Health visits | 145 | |
| Immunisation visits | 3,841 | |
| Miscellaneous visits | 8,347 | |
| | 55,043 | 10,483 |
| GRAND TOTAL | 65,526 | |

| Clinic Sessions | Health Visitor | Clinic Nurse |
|---|---|---|
| Full sessions | 2,006 | 436 |
| Part sessions | 2 | |
| TOTAL | 2,008 | 436 |

**Nursing Auxiliaries (a) Visits**

| Type of Visit | Access | No Access |
|---|---|---|
| Bathing – children | 712 | |
| Bathing – aged infirm | 1,736 | |
| Foot hygiene – aged infirm | 4,340 | |
| Miscellaneous – aged infirm | 1,321 | |
| Miscellaneous – general | 93 | |
| TOTAL | 8,202 | 24 |

**Nursing Auxiliaries (b) Clinic Sessions**

| Type of Clinic | | Sessions |
|---|---|---|
| Screening tests of hearing, with Health Visitor | equivalent of | 82 |
| Child Welfare with Health Visitor | ,, | 441 |
| Day Training Centre with Specialist Health Visitor | ,, | 150 |
| School Minor Ailments including Mobile Clinic with Clinic Nurse | ,, | 819 |
| Chiropody – school children with Chiropodist | ,, | 337 |
| Chiropody – elderly with Chiropodist | ,, | 338 |
| Special bathings – school children | ,, | 145.5 |
| School medical examinations with Doctor | ,, | 119 |
| Cleansing | ,, | 42 |
| Camp examinations with Clinic Nurse | ,, | 11.5 |
| Health check-up with Clinic Nurse | ,, | 215 |
| Syringe Service | ,, | 704 |
| TOTAL | | 3,404 |

**Nursing Auxiliaries (c) School Sessions**

| Type of Work | | Sessions |
|---|---|---|
| Assisting at Health Survey with Health Visitor | equivalent of | 264 |
| Vision Testing | ,, | 91.5 |
| Hygiene Inspection | ,, | 334 |
| Hygiene Re-inspection | ,, | 99 |
| School medical inspections with Doctor | ,, | 134 |
| Assisting with immunisation in school with Clinic Nurse | ,, | 96 |
| Miscellaneous | ,, | 16 |
| TOTAL | | 1,034.5 |

# HOME NURSING SERVICE

The District Nursing Service has continued to give nursing care to those people in the City who have needed the services of a highly trained nurse in their own homes. We have been helped by the manufacturers of disposable goods. Their newest offerings from the plastics divisions have given the district nurse lightweight, hard wearing, easy to clean equipment, plastic bags in which to carry her equipment, and fine white clinical sheeting to use for protection of the patient's property when carrying out treatment in the home and to give a clean working surface. Moulded plastic gloves give improved sense of touch and add to the comfort of the patient, improved material for syringes results in easier injection therapy with, most important, maximum safety.

With the decentralisation of the nursing service we have had increased co-operation with the other departments, as the field workers have been able to meet and discuss patients' needs, and multi-visiting has been decreased but more intensive care has been given.

The evening visiting for patients who need special care has continued, fulfilling a special need, especially for relatives who need help and reassurance during acute and terminal illness of patients.

| | |
|---|---|
| Average number of visits during the year | 1,980 |
| Average number of visits during each month | 165 |
| Average number of visits during each night | 5 |
| General Nursing Care | 20% |
| Injections | 80% |
| Type of injections | |
| Antibiotics | 5% |
| Inferon | 15% |
| Dangerous Drugs | 80% |

Sources of referral have followed the pattern of previous years with the General Practitioner heading the list. With the increase of attachment of the District Nurse to the general practitioner service, this referral rate will rise and thus giving earlier nursing care to those who need our services.

The development of the Health Team from the attachment of the District Nurse to the General Practitioner is rapidly progressing in the city. The Health Team operates with regular meetings between the Social Worker, the Health Visitor, the Midwife, the General Practitioner and the District Nurse, when discussions of patients and their problems can be more adequately assessed and care given with greater understanding. The District Nurse with daily visits to the surgery, is able to give earlier nursing care and reassurance to the patient, rehabilitation is established, and hospital admission is reduced.

The Health team is a new concept of community care and should break new ground in giving concentrated nursing care to those who wish to remain in their own homes during periods of ill health.

**Referrals**

| | 1964 | 1965 |
|---|---|---|
| General Practitioners | 1,401 | 1,394 |
| Hospital | 321 | 240 |
| Health Visitor | 59 | 50 |
| Personal Application | 14 | 14 |
| Midwifery Service | 4 | 1 |
| Others | 33 | 37 |
| TOTALS | 1,832 | 1,736 |

| | | 1964 | 1965 |
|---|---|---|---|
| Number of Patients | removed from our care | 1,787 | 1,698 |
| | recovered | 898 | 806 |
| | transferred to hospital | 339 | 333 |
| | removed from district | 28 | 33 |
| | removed for other causes | 323 | 282 |
| | died | 199 | 244 |

**Number of patients treated during the year**

| Age groups | Patients | Visits |
|---|---|---|
| 0 – 4 years | 80 | 581 |
| 5 – 14 years | 61 | 280 |
| 15 – 39 years | 317 | 4,307 |
| 40 – 64 years | 632 | 18,430 |
| 65 – 75 years | 532 | 16,437 |
| 75 plus years | 721 | 21,716 |
| TOTALS | 2,343 | 61,751 |

During the year, 2,343 patients have received 61,751 visits from the District Nursing Service.

We have nursed 93 patients suffering from infectious diseases, ranging from tuberculosis to broncho-pneumonia and they have had 1,216 visits. 164 patients who have been referred to us having carcinoma have had 4,998 visits. Some of these visits have been during the late evening, when comfort, re-assurance and relief of pain during the night, is essential.

Coronary diseases and disorders of the circulation involved the district nurse in intensive rehabilitation of 349 patients and, with the help of the physiotherapist, they have paid them 10,705 visits during the year.

Chronic chest conditions have disabled 142 patients who have received 1,528 visits.

Anaemia, which involves many old people, was the cause of 6,268 visits to 282 patients. 31 patients suffered from diseases of the central nervous system which mainly occurs in middle age groups and received 983 visits.

Those patients suffering from mental illness do not need as much nursing care, as only 9 patients had 174 visits.

100 mothers who developed anaemia or any complications during their pregnancies received 833 visits from the district nurse.

Rheumatoid arthritis and a group of other medical diagnosis claimed 632 patients and 12,181 visits were paid.

Pre X-Ray investigations were constant, 12 patients needing 25 visits.

There were 125 old people who for reasons of age, received 4,428 visits.

Post-operative conditions, ulcerated legs, and those patients needing wounds redressed numbered 343, and 9,672 visits had to be paid.

The staff have remained fairly constant throughout the year and have given good service to their patients.

We have had visits from students from the local hospitals and from other countries and disciplines who have been sent on observation visits.

Our own students have been successful in gaining the certificates of the Queens Institute of District Nursing and the Certificate of the Ministry of Health.

## STAFF CHANGES

### Queen's Nursing Sisters

We have had two resignations, one left to work in another area, and one to return to hospital.

### State Enrolled Nurses

Two have resigned, one to return to Ireland, and one to undertake duties in a welfare home for old people.

### Students

We have had seven students during the year, who have successfully undertaken district training. We have also had Diploma students who have successfully undertaken district nurse training.

We held an exhibition of disposable equipment in July, which attracted some attention and gave members of the department insight into the vast array of material which could be provided and also some of the problems of disposing of this material when it had been used. Much of this material was paper, so could be burnt, but not in a smokeless zone, and the polypropalene materials need an incinerator. With the wide range of disposable syringes, we were able to send our diabetic patients on holiday, with their own special syringes, secure in the knowledge that by using disposable equipment there was no danger of breakage or not having a sterile syringe and needle, especially when they were at a holiday camp.

Incontinent sheets have improved in texture and absorbability during the past year and we have a small but steady use for these articles in emergency before our laundry service can be brought into operation.

The laundry service is fulfilling a need which is used for the elderly incontinent person. When this service is in operation the relatives can manage to care for sick patients with greater ease and less physical exertion. This is important when patient and relatives have reached retiring age and find that new and unaccustomed strains are being put upon them as a result of the illness.

Loan equipment is in constant use and we have added to our stock for lending to patients Dunlopillo mattresses, fracture boards and rail walking aids. These aids are very useful for those who have spent some time in bed and need extra help and encouragement to try to return to their former degree of mobility.

Loan equipment can be obtained from the district nursing centre during the day between the hours of 8.30 – 9.30 a.m., 1.30 – 2.30 p.m. and 4.0 p.m. to 4.30 p.m.

With the opening of the home nursing centre at Trinity Centre on Rosamund Street the patients residing in this area are able to obtain equipment more easily than before ; this is essential when frail relatives require help as they can visit the nurse and discuss the amount of help required.

The Marie Curie Memorial Foundation Fund has been able to supply extra help to those families who are caring for patients suffering from cancer, especially when resources are strained during a long and trying illness.

Night nursing and equipment such as bedding, blankets, pillows and sheets have been supplied. We have also been able to supply extra nourishment when the appetite has been diminished, usually supplies of 'Complan'.

For the future, we are exploring the possibilities of greater co-operation with the general practitioner in the field of family health. The relationship between the district nurse and the general practitioner has always been very good and care given to the patients has been of a high standard. In the changing pattern of care needed by patients, this must be in depth so that adequate support to those in need is given without multi-visiting, wasted visiting, and the highly skilled services of the district nurse are not wasted.

# CHIROPODY SERVICE

The Salford Health Department continues to provide a chiropody service as part of its arrangements for the prevention of illness under Section 28 (1) of the National Health Service Act, 1946.

Priority is given to the elderly, the physically handicapped, and expectant mothers.

This service continues to be in great demand throughout the City and the number of chiropody treatments provided is only limited by the number of staff available to see the patients.

Regular chiropody clinics are held at the Langworthy Clinic, Regent Road, Murray Street Clinic, Kersal Centre and at Trinity Clinic. Kersal Clinic, although relatively new, has become very busy, 917 chiropody treatments being given there during 1965; and there can be no doubt that the new Trinity Clinic will become popular with foot sufferers in the Salford, 3 area. Some of the semi-ambulant patients in the Salford, 3 area now attending Kersal Centre by sitting car can be diverted to Trinity and a number of patients, who, because they cannot make their way to one of the more distant clinics on foot, have to be conveyed by sitting car, can now reach the Trinity Clinic without help.

It must be assumed that smaller clinics strategically placed throughout the City are of far more value to the community than the large central clinic, at least as far as the chiropody service is concerned. If the elderly person is not faced with a difficult journey to the clinic he will more readily attend when he feels that he may need attention or advice, and the result of having a conveniently situated clinic will mean that many of the foot lesions to which the elderly are prone receive early treatment and are not allowed to develop into the more serious conditions which may cause the person to become housebound or lead to hospitalisation.

Our aim must be to keep the elderly mobile, and to this end the chiropodists do all in their power.

One of the more obvious reasons for the popularity of the chiropody service is the immediate relief that the patient experiences after treatment by the chiropodist. Even the minor conditions which the chiropodist has to treat such as the ingrown toenail or corns and callosities can be excruciatingly painful, but the patient knows that at the chiropody clinic, often in a matter of minutes, he can be provided with long lasting relief; and so it is not surprising that the chiropody service will expand with the increase of the local health authority's ability to provide chiropody clinics.

It is estimated that about 25% of the over-sixty age group are in need of regular chiropody treatment and there is a substantial percentage of the working age group who would benefit by chiropody treatment (see Annual Report of the Medical Officer of Health, City of Salford, 1964 p. 122), so one may assume that any expansion in local health authority chiropody services will best be effected by accepting patients on medical need rather than by

age grouping. There must be many elderly people who feel that as chiropody clinics exist, then they must be made use of, irrespective of whether they require the service or not. Acceptance of patients on medical need would allow for the treatment of any citizen irrespective of age who required our services without straining the service to too great an extent.

An effective solution in coping with the increasing demand for chiropody treatment may be the provision of two types of clinic – the "high risk" clinic and the "normal foot treatment" clinic. The "high risk" clinic would be for those requiring frequent intensive treatment, while the ordinary clinic would cater for those patients whose feet need only be attended to at the interval between treatments necessitated by the ratio of staff to patients. The not uncommon problem of the diabetic neuropathic lesion on the ball of the foot is one which must be recognised when deciding the frequency of treatments. These patients may need to be seen more frequently than is at present possible without swamping the clinics with too heavy case loads, whereas the elderly person in comparatively good health with a reasonably good peripheral circulation does not need to attend the clinic more than two or three times per year.

One cannot generalise as to the interval between attendances at the chiropody clinic. There should be no reason why a patient who exhibits the more serious lesions resulting from diabetes and peripheral vascular disorders cannot be seen frequently at the "high risk" clinic until these lesions have cleared up, when they may be then transferred to the ordinary clinic for treatment at the far less frequent intervals sufficient to keep their feet in good condition.

The "high risk" clinic should be associated with a chiropdial appliance unit, as experience has shown that one of the greatest aids to the resolution of a diabetic neuropathic lesion on the foot is a permanent removable appliance correctly made and fitted.

During the year, several visits have been made to the Crescent Adult Training Centre and arrangements have been made for a chiropodist to visit Broad Street Adult Training Centre at regular intervals.

It is gratifying to see that, as time goes on, more family doctors are referring patients to the chiropody clinics when it is felt that chiropody is the treatment of choice; it would be wasteful in time and effort not to make full use of the knowledge and techniques of the specialists in the supplementary professions.

The satisfaction of the demand of the homebound for domiciliary chiropody treatment is an ever-growing problem for two reasons – one is the time factor, in which the chiropodist may spend as much time in travelling as in giving treatment, and the other is the conditions in which the chiropodist may have to work in the home of the patient. Some of the homes are badly lit and in many ways not suitable for carrying out minor operative procedures, and so the domiciliary chiropodist has often to modify to some extent his treatment to prevent the risk of infection, etc.

The preceding difficulties have to a large extent been kept within bounds by the continued help of the ambulance staff who have been most co-operative

in transporting to the clinics many patients who would otherwise have had to receive treatment at home.

Although the direct chiropody services of the local health authority are no longer a new venture they still continue to uncover a demand for treatment which at the moment seems insatiable, but no doubt as time progresses the service will cope better than adequately, and the day-to-day problems that occur within the service are more than compensated for by the patients' gratitude and trust.

## CHIROPODY FIGURES FOR THE YEAR (CARE OF THE ELDERLY)

| | | | | |
|---|---|---|---|---|
| **Totai Number of Patients on Register at 31st December, 1965** | | | | 2,332 |
| Number of Walking Cases | 68% | | | 1,587 |
| Number of Sitting Car Cases | 15.3% | | | 357 |
| Number of Domiciliary Cases | 16.6% | | | 388 |
| | | | | 2,332 |
| **Totai Number of New Patients referred to the Chiropody Ciinics during 1965** | | | | 494 |
| **Langworthy Road Ciinic** | | | | |
| Sitting Car Cases | Male | 60 | | |
| | Female | 456 | | |
| | | | 516 | |
| Walking Cases | Male | 330 | | |
| | Female | 1,858 | | |
| | | | 2,188 | 2,704 |
| **Regent Road Clinic** | | | | |
| Walking Cases | Male | 203 | | |
| | Female | 990 | | |
| | | | | 1,193 |
| **Murray Street Clinic** | | | | |
| Walking Cases | Male | 132 | | |
| | Female | 741 | | |
| | | | | 873 |
| **Kersai Clinic** | | | | |
| Sitting Car Cases | Male | 27 | | |
| | Female | 251 | | |
| | | | 278 | |
| Walking Cases | Male | 123 | | |
| | Female | 516 | | |
| | | | 639 | 917 |
| | | | Clinic Total | 5,687 |
| | | | Domiciliary Total | 1,304 |
| | | | Grand Total | 6,991 |

**Total Number of Clinic Sessions Held in 1965** — 896

| | | | |
|---|---|---|---|
| Sessions at Langworthy Road | Day | 428 | 428 |
| Sessions at Regent Road | Evening | 48 | 188 |
| | Day | 140 | |
| Sessions at Murray Street | Day | 135 | 135 |
| Sessions at Kersal | Evening | 50 | 145 |
| | Day | 95 | |
| | | | 896 |

**Total Number of Patients Invited to Clinics during 1965** — 6,533

**Total Number of Patients who attended Clinics during 1965** — 5,687

| | Invited | Attended | Defaulted |
|---|---|---|---|
| Langworthy | 3,159 | 2,592 | 567 |
| Regent | 1,392 | 1,130 | 262 |
| Murray Street | 1,054 | 854 | 200 |
| Kersal | 928 | 848 | 80 |
| | 6,533 | 5,424 | 1,109 |
| | | (83%) | (17%) |

Attended 5,424

**Number of Additional Cases**

| | |
|---|---|
| Dressings | 98 |
| Observation | 2 |
| Emergency | 163 |
| | 263 |

Attended 263

5,687

**Total Number of Treatments Given**

| | | | | |
|---|---|---|---|---|
| Treated at Clinics | 12.5% | Male | 874 | 5,687 |
| | 68.8% | Female | 4,813 | |
| Treated at Home | 2.9% | Male | 209 | 1,304 |
| | 15.6% | Female | 1,095 | |
| | | | | 6,991 |

# HOME HELP SERVICE

The Home Help Service has continued to provide help for the sick and aged in their own homes. Due to early discharge from hospital and the large amount of preventive work with problem families there are varying degrees of priority in this work, and the immediate need and urgency must be carefully assessed in each individual case in order that the highest priority cases have first call on this service.

The following figures show an increase of 137 in the total households assisted in 1965 as compared with the previous year :–

| | 1964 | 1965 |
|---|---|---|
| Aged 65 and over | 1,655 | 1,761 |
| Chronic sick and tuberculous | 200 | 224 |
| Mentally disordered | 7 | 8 |
| Maternity | 65 | 75 |
| Others | 75 | 71 |
| | 2,002 | 2,139 |

| | | |
|---|---|---|
| Caseload at beginning of year | 1,509 | |
| New cases helped during year | 630 | |
| Total cases helped | | 2,139 |
| Cases terminated during year | 508 | |
| Caseload at end of year | 1,631 | |

| | |
|---|---|
| Number of Home Helps employed at the end of 1965 | 277 |
| Average weekly number employed | 275 |
| Total number of hours worked throughout 1965 | 267,775 |
| Weekly average hours worked | 5,052 |

This bare statement of figures however gives little indication of the real extent of the service and the amount of comfort and attention generated by the staff engaged in this work.

The few hours per week allocated to most of our elderly cases are sufficient only for the weekly cleaning in their houses : but one hears of washing being taken home voluntarily by the Home Help and weekend shopping undertaken. Often a bed is moved downstairs into the warmth of the living room for the winter, and fresh curtains and bed-covers are supplied by the Home Help. Small though they seem, these little things make a valuable

contribution to the care of the elderly in the community. Old people dislike changes and can become unduly worried about uncertainties, and in certain circumstances it is a happy arrangement if the same Home Help can continue to attend at the same case.

Special cases of sickness with problem families and preventive work to avoid family breakup have all received priority attention and often daily care. Though it has never been expected that spectacular results could be achieved quickly, in some cases the Home Helps have done magnificent work, and by their commonsense and resourcefulness have prevented further deterioration and in many cases have secured improvement in home conditions.

Mothers with young children have received substantial help, and health visitors especially are quick to bring to our notice such cases where the mother is overburdened and some help would be beneficial to health and family life.

There has been an increase in help supplied for maternity cases, 75 cases as against 65 in 1964. But requests for help for these cases still come in without any previous warning and it would be beneficial if expectant mothers could be encouraged to 'book' a Home Help in advance in order that the need could be forecast beforehand and arrangements completed.

During the year 858 applications for help were received, and 630 were accepted as being in need of assistance from the Home Help Service.

Sources of application (expressed in percentages):–

| | | |
|---|---|---|
| Health Visitors | 249 | 29% |
| Hospital Almoners | 128 | 15% |
| Self | 120 | 14% |
| Friends and Relatives | 89 | 10% |
| General Practitioners | 80 | 10% |
| Civic Welfare Department | 52 | 6% |
| National Assistance Board | 41 | 4% |
| District Nurses | 34 | 4% |
| Midwives | 20 | 2% |
| Housing Department | 13 | 2% |
| Cripples Help Society | 11 | 1% |
| School Welfare | 8 | 1% |
| Home Helps | 7 | 1% |
| Mental Health | 6 | 1% |

Applications for the services of a Home Help continue to increase and the growing number of requests entail consequent visiting. Often the supply of help does not catch up with the demand and much time is consumed in dealing with applications from people who think they should get a "cleaner" immediately, and who are inclined to use this service as a free domestic agency.

There has been some difficulty in trying to maintain adequate supervision on the district. The good reputation of the service is valuable and must be upheld and could easily be lost by bad time-keeping and poor work. Absenteeism for sickness or domestic reasons also drains the resources of the help available and casts an extra burden on the staff dealing with complaints, enquiries and demands.

The In-Service Training Scheme for Home Helps has continued throughout the year, and selected Home Helps have attended a 30-hour programme which provides for lectures, demonstrations, films and discussion groups. There is no doubt that this training has proved to be beneficial and it has encouraged the Home Helps to apply themselves to their task with greater confidence and understanding of the work involved.

# MENTAL HEALTH SERVICE

## INTRODUCTION

Since 1957 the report of the Salford Mental Health Service has been edited by Dr. M. W. Susser who, as Senior Assistant Medical Officer for Mental Health was responsible for the planning of the statistical data and the conclusions and comments arising from them. This report includes similar statistical information to previous years but inevitably in the absence of Dr. Susser the present writers will make a more modest contribution in drawing conclusions from these figures.

We have taken the opportunity, therefore, of discussing in some detail the problems which have occupied our thoughts throughout the year, as well as the ultimate goals we have in mind. Developments in 1965 can be seen to follow the trend towards integration of the mental health services in four different areas :–

1. The adult psychiatric services, where joint facilities and joint personnel have brought hospital and community closer together than ever before;

2. The child psychiatric services, where child guidance clinic, mental health department and health visitors have to work closer together;

3. The services for the subnormal, where maternity and child welfare has become more involved, and the development of the retardation unit at Royal Manchester Children's Hospital offers further hopes for the future;

4. The family doctor services, in which by the end of the year, several 'health teams' including mental health social workers, health visitors and district nurses were working.

These four areas of integration we see as growing points of the service as we move towards truly comprehensive mental health services for the people of Salford.

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Recently interest has been shown in the history of the department over the past ten years*; yet in many ways 1965 was one of the most important.

Co-incident with the loss of the Senior Assistant Medical Officer for Mental Health, who was promoted from part-time senior lecturer to full-time Reader-in-Charge of the department of Social and Preventive Medicine at Manchester University, and the departure of Dr. A. G. M. Wiseman to pursue a career in clinical psychiatry, all but the most senior of our experienced social workers left Salford.

Such a complete staff turnover could have been disastrous for the Community Mental Health Service as a social work agency. However, with a fair share of good fortune, helped by the reputation Salford has achieved and a determination to avoid recruiting unqualified workers, we attracted, by the time of writing, a full establishment of qualified staff including three

* Since published in the Monthly Bulletin of the Ministry of Health and the Public Health Laboratory Service 1966, 25, 24.

psychiatric social workers, (one of whom occupied a joint appointment with the Springfield Hospital Management Committee). Two further trained social workers are expected to join the service shortly.

At the same time, 1965 has seen many of the recommendations of previous reports, if not brought to fruition, at least accepted throughout the service as necessary goals. Much of this report is concerned to describe and discuss developments along these lines.

## ORGANISATION OF MENTAL HEALTH SOCIAL WORK

Since 1958 the allocation of social work has been by reference to the general practitioner: each mental welfare officer has taken cases from a pre-arranged list of family doctors. This method was introduced so as to encourage closer liaison and co-operation between doctor and social worker, and to a large extent it proved a success, at least with a number of family doctors. However, it has several inherent weaknesses which made modifications inevitable. The system allowed no rational allocation of social work in which training, aptitudes and ability were matched with the particular demands of the case; considerable variations in case load could not be avoided, and the absence of workers, sick or on holidays always gave rise to complications. Moreover the system was inimical to systematic case work, since any mental welfare officer could be called to handle a day-time 'emergency' if one of his general practitioners was involved. Few appointments could be made and we believe the work suffered from the lack of individual work organisation the system encouraged.. The difficulty has been accentuated by the impossibility, until recently, of proper formal supervision of the case-work predominantly undertaken, as it is, by younger and less experienced members of staff. An attempt has been made therefore to resolve these difficulties, whilst retaining the principle of closel liaison with the family doctors.

Pairs of workers now share enlarged panels of general practitioners, and all workers in rotation take a day's emergency calls, allowing them better to plan their work ahead. The three professionally trained social workers undertake a formal weekly supervision period with the remainder of the social work staff. The weekly case conference, and the lunch-time seminar allow full discussion by the whole department of all matters relating to the work. All members are encouraged to take an active interest in the development of new ideas and methods, and in evaluating both the administrative framework and individual case-work.

The development of using professionally trained social workers as supervisors of the less trained and experienced persons is in keeping with the proposals set out in the Younghusband Report. This Report envisaged that there should be three grades of workers: those with post-graduate social work training should undertake the most responsible case-work, though the majority of social workers in the Health and Welfare Services would be those with the Certificate in Social Work Training. The third grade of worker would be younger people receiving in-service training prior to undertaking a formal social work course, or older untrained people who could make a contribution by undertaking the less skilled and more routine work.

During the year it has become clear that better use could be made of the trained social work staff if we had available this third grade of worker to

undertake many of the routine tasks that do not require any special skills. It was also recognised that though the department has been fortunate during the last two years in attracting trained people direct to its service, we should accept responsibility for enlarging the pool of trained social workers, and of course, at the same time prepare for the exigencies of the future by taking young people as trainee mental welfare officers, giving them in-service training and undertaking to sponsor them later on a 'Younghusband Course'.

These changes in social work organisation have also improved the department's service to social work students who can now be more readily allocated suitable work and offered proper supervision.

**Work Profile of The Mental Welfare Officer**

Only three social workers who undertook the full duties of a mental welfare officer were in continuous service throughout 1965. It is of interest to look at the average work load of these three, and so obtain some idea of what is expected of a mental welfare officer in Salford.

1. He would receive 113 psychiatric referrals during the year, 26 of which would be emergency calls undertaken outside normal office hours.

2. Out of the 52 weeks in the year he would be on call duty, out of hours, for 10 weeks.

3. At any particular time he could expect to have a case load of 50.

4. One night per week would be spent at a psychiatric social club.

5. He would keep in close touch with one hostel, day centre or training centre and undertake any social work arising from this source in addition to (3).

6. Most weeks he would attend both case conference and seminar in the Health Department and participate in a staff-patient meeting at Springfield Psychiatric Hospital.

7. He would make 1,100 visits during the year, 120 of which would be concerned with the assessment arising from a new episode of mental illness. One visit in ten would prove abortive, largely because there was nobody at home at the time the call was made.

It can be seen from Appendix IV that while the number of cases referred to the Department remains comparatively steady, there has been a marked drop in the number of visits made by social workers. Three factors may have contributed to this reduced figure.

This year has seen great changes and new inexperienced workers have replaced those who, because of their experience, were able to work more efficiently, but the most important factor is that several of the newly-recruited workers have been unable to afford to buy a car. The Annual Report of 1958 showed clearly that personal transport enabled two workers to do as much visiting as had previously been undertaken by three. This must still hold true and the department will remain handicapped until help is given to

young Mental Welfare Officers to purchase cars. Another possible reason for the apparent reduction in the number of visits was the introduction of a new, rather complicated monthly form of recording visits which initially may not have been fully completed. A simplified form has been introduced for 1966.

**Emergency Calls**

The personal restrictions of having to be available for duty out of hours can readily be understood to be an obstacle to recruitment of trained staff to the community mental health service. It is less readily appreciated that this may not be the most disadvantageous aspect of the work. Under the 1959 Mental Health Act, a patient's admission to hospital can be effected without recourse to the mental welfare officer, except in the absence of a co-operative relative. In Salford the mental welfare officer is almost invariably involved in out of hours admissions to psychiatric hospital, which seems to indicate that he is providing a service to both family doctor and receiving hospital, as well as providing for the patient and his family a trained social worker in a difficult situation. Yet in providing this service he may rarely be able to please all parties.

The demands of the family doctor and the psychiatric hospital frequently conflict, and if he serves the wishes of the one, this is only to provoke hostility in the other. Many general practitioners have had very limited training in, and experience of, psychological medicine and when confronted with seriously deviant behaviour, particularly in a patient with a psychiatric history, they may understandably feel that it would be safer for all concerned if such behaviour were contained within the hospital. The psychiatric hospital on the other hand is increasingly concerned to establish its therapeutic orientation and minimise its custodial function to reinforce its image as a "Hospital" for recognisable psychiatric illness. It is not eager to admit patients with character abnormalities and those whose problems largely arise from their modest endowment. While the mental welfare officer may understand the genesis of these points of view, this is of little value in the early hours of the morning. Whilst trying to exercise his professional responsibility, whatever action he takes in this situation will displease somebody, and he must learn to live with much anxiety and frustration in the relative isolation of 'night call'. Insufficient junior medical staff in the hospital further exacerbates this difficult situation.

An important issue arises from this situation that must be faced if professionally trained social workers are to be recruited and retained. In few fields of social work are such onerous duties, 'out of hours', expected as a regular feature of employment. The recent salary award giving social workers in hospitals parity with those in local authorities, but without the burdens and responsibilities of community mental health work, adds to the problem. Highly demanding 'out of hours' duties should be recognised in salaries, and not all workers are able or wish to do them. If these duties were treated as extra 'sessions', payments could be made accordingly and individual officers could be allowed some degree of choice in whether they performed them – for extra payment – or not. The present general addition of a small lump sum to the annual salary is unsatisfactory, and time off in lieu would hardly allow normal day-time work to continue. Unless this matter is faced we may expect a migration of trained staff from the community mental health service to the comparatively sheltered conditions of the hospital and other social work agencies.

**Students**

As has been mentioned in previous reports the policy of the Mental Health Service is to accept responsibility for providing practical work placements for social work students. During the year, in addition to accepting two Certificate in Social Work Students for six month periods, two attended one day per week for a term, from the Manchester University Department of Social Administration. Furthermore, the N.A.M.H. Course for Teachers of the Mentally Handicapped were permitted to send students to the Department to gain some insight into the work of the Mental Welfare Officer. Both Crescent and Kersal Hostels benefitted from having a student resident for a period and casting an objective eye on their internal organisation.

It is worth noting that whilst students have a beneficial, stimulating effect on the Service as a whole, it does require a considerable amount of time from those workers who can provide teaching and supervision. If this task is to be performed adequately and extended to meet future demands, it may be that colleges of social work should make some contribution towards the cost of employing the necessary skilled staff.

**Future Trends**

Perhaps the only certainty for the social services during the next decade is of great structural changes. Divisions within them will change or disappear, and Local Government itself may have discovered an entirely new form. The precise nature of these changes cannot be forecast, but one thing is clear; no matter what type of agency is responsible for community mental health work, the recruitment of able professional staff must be an absolute priority if the service is to meet the needs of those for whom it is intended. For all such staff there will have to be enhanced career prospects. If the service is to recruit and hold highly trained workers, then the prospects and conditions of work cannot afford to be less promising than those in Child Care, Welfare, Probation and Education.

Local authorities could offer a unique pre-training experience in generic social work if trainees were appointed to rotate through all local personal services. Yet the problem of local authorities in financing formal training and retaining trained staff will remain until central government accepts financial responsibility.

Policies of secondment for training vary greatly from one authority to another and many untrained but experienced workers are denied the opportunities to obtain essential qualifications Some authorities appear to have no policy at all, whilst others warned by experience, are understandably reluctant to pay for the professional training of workers who for one reason or another will remain in their service for a minimal period only.

## DEVELOPMENTS IN THE SERVICE

Previous Annual Reports have emphasised the need to co-ordinate the services of the hospital and local authorities, recognising that such services are complementary and neither is able to function efficiently without the other. This view has been clearly emphasised by the Ministry of Health's Circular H.M. (64) 45.

The joint appointment of a consultant psychiatrist, with responsibilities in both general and mental hospitals in addition to the mental health service, was a very important step, but left much to be achieved at field level. Access to the mental hospital by mental welfare officers has been available for some time, but there still exists problems deriving from poor understanding of the special difficulties of work in different settings. The joint appointment in 1965 of a psychiatric social worker to the psychiatric hospital and the local authority mental health service was recognised as a potential way of breaking down some of the real and imaginary barriers to fruitful co-operation. It is much too early to evaluate the success or otherwise of this appointment, but already certain measures have been introduced that should contribute towards a better understanding by all concerned. The introduction of a weekly meeting for patients, nurses and mental welfare officers led by the psychiatric social worker, and attended, when possible by the consultant psychiatrist has not only allowed patients and staff to meet and communicate openly with one another by raising problems of mutual interest, but also provides an opportunity to examine prejudices and distortions that would not previously have been openly discussed. Of equal importance is the opportunity following the patient staff meeting for hospital and local authority workers to continue to discuss any problems of mutual concern. It is unfortunate that such progress in hospital local authority co-operation should be marred by the absence at these meetings of junior medical staff. The shortage of medical staff in both the psychiatric hospital and the unit at Hope Hospital must be considered with extreme urgency if the whole service is not to be placed in jeopardy. An interesting proposal to ease the problem, which has many attractions, is the joint appointment of a medical officer to undertake duties in both hospital and public health services. Such a measure would have the advantage of affording medical staff with the necessary experience in the community as well as the clinical setting of the hospital, and it is hoped to pursue this in the coming year.

Another venture in hospital local authority co-operation has evolved between Hope Hospital Psychiatric Unit and the Mental Health Service Cleveland House Day Centre. Again it is too early to claim success but there are indications that many hospital patients attending the day centre have found this to be a helpful experience. Suggestive of this is that a number of them have felt the need to keep in contact by attending the newly-opened evening social club which is held in the same premises and organised by the same staff members. As with other ventures the introduction of this service highlights the need for others. From formal and informal discussions with hospital patients there appears to be a need for more help from a trained caseworker to deal with the many psycho-social problems that inevitably arise for patients under treatment. This makes the return from the University next year of Mrs. Banning, to take up the post of joint psychiatric social worker to the general hospitals and the local authority, all the more welcome.

Until this year it has not been possible to allocate time from the pressing emergency and preventive work to provide social histories on psychiatric patients attending the out-patient clinics. This work was first undertaken almost exclusively by Certificate in Social Work Students who attend Salford Mental Health Service for their social work placement, but later the work was undertaken by mental welfare officers. With Mrs. Banning's return this side of the work should be developed and organised more effectively than has been possible up to now.

**Cleveland House Psychiatric Day Centre**

The evolution of facilities at Cleveland House has continued throughout the year. In 1964 a part-time occupational therapist was appointed to cater for a younger group of women who still required considerable support following in-patient or out-patient treatment in hospital. During 1965 she was replaced by a full-time art therapist with experience in occupational therapy, art teaching and social work, and the centre has been opened to psychiatric in-patients from Hope Hospital. Their introduction has not been without difficulties, although it has been welcome to the staff of both hospital and centre. To the advantage of Cleveland House it brings patients with acute psychiatric disorders, many from a higher social class than is normally accommodated, and creates greater opportunities for providing a more stimulating and therapeutic milieu than would otherwise be possible. This makes extra demands on the staff, but provides a legitimate outlet for their undoubted skills and enthusiasm.

Unfortunately the physical characteristics of Cleveland, – insufficient accommodation and poor decor, compare unfavourably with the newly decorated psychiatric ward at the hospital, and have provided a plausible focus of discontent for a small but important group of patients. Their general disatisfaction with life and their criticisms about the hospital regime have found an easy outlet with Cleveland House as the scapegoat. Yet it is interesting to note that several of the 'ring leaders', who have been most vocal in their hostility to the day centres, are those who have continued to seek help and support from the staff at Cleveland House long after they have been discharged from hospital.

Another development has been in allocating one room and a newly-recruited member of staff to the care of a small group of male and female psycho-geriatric patients. These elderly people, who are brought to the centre each week-day by ambulance, would undoubtedly require admission to hospital in the absence of day care. As with all centres and hostels an important concomitant of this facility is adequate social work coverage to deal speedily with any social crisis that may occur at home, and to maintain an awareness of the limits of tolerance of relatives who are clearly bearing the major burden of this aspect of care in the community.

Cleveland House re-emphasises that most psychiatric services demand joint enterprise between clinical medicine and "community care". Planning for future needs requires the hospital and local authority to plan together so as to avoid wasteful overlapping in both capital expenditure and the use of scarce, skilled staff.

**Hostels**

In previous Annual Reports and elsewhere*, comment has been made on the difficulties of effective organisation of the Salford Hostels to ensure the fulfilment of their intended function. Initially it was considered that the hostels should provide a suitable milieu to enhance the social competance and emotional maturity of the residents. Heterogeneity in matters of age, psychiatric diagnosis, social class, etc., were seen not as a contra-indication to acceptance but rather as creating a social situation that could be used in a constructive way. It was argued that this method avoided the inevitable alienation from the community found in institutions where intake is restricted by strict social criteria ; for example, borstal institutions, prisons and public schools.

Needless to say if a hostel is to do this effectively, considerable understanding and expertise is required by the residential staff. Salford with most other authorities, has experienced difficulty in obtaining staff with appropriate ability and enthusiasm. It is not surprising that the general problems of recruiting staff for residential work with its special demands and unusual attractions are accentuated in institutions caring for the mentally disordered.

In addition to the limitations of the residential staff, a further factor has contributed to the change in organisation of the hostels. The demand for hostel places from hospitals has included many patients with such severe personality damage that it would be unrealistic to expect progress to anything approaching independent life in the community. A firm line will have to be taken if we are to prevent the hostel from becoming an extra-mural chronic ward of the psychiatric hospital, with no appreciable benefit to patients and making increasing demands on the limited resources of the hostel and day centres, and community workers. Not only is there the problem of transferring the cost of custody of such patients from national funds to the ratepayer, but there can be little doubt that such a transfer actually increases the cost of keeping a person in care. The question is not whether custodial care should be undertaken by the hospital or the local authority ; a good argument can be made out for either. But if the local authority accepts this responsibility, the change should be openly acknowledged and adequate resources made available. Clearly custodial care has a limited goal, and facilities, in scale and cost, one would expect to be comparable with the best of present Part III accommodation. Psychiatric hostels cost a great deal more (one hostel set up by a County Council for psychiatric patients is costing £40 per week per patient, excluding services provided outside the walls of the hostel), and can only be justified if residents, in a relatively brief stay, receive effective rehabilitation to comparative independence in the community.

At the time of writing an interesting experiment has been introduced into one of our hostels. Rather than attempt to recruit residential staff from the traditional sources : ex-mental nurses or staff from Old People's Homes etc., a young professional couple have taken up residence at Kersal Hostel. The wife was a grammar school teacher and now holds the appointment of Warden whilst her husband is the psychiatric social worker jointly appointed to the mental health service and the local psychiatric hospital. Another mental health social worker also lives in the hostel, rent free, and helps in the day-to-day organisation and work.

*Mountney, G. H. Local Authority Psychiatric Hostels. The British Journal of Psychiatric Social Work. Vol. VIII 1965 No. 2.

The advantages of this experiment are threefold, firstly it introduces three young enthusiastic and intelligent workers into the hostel. In normal circumstances one could not expect to recruit this calibre of worker into residential work at present salaries. Secondly, one may expect a freshness of approach and a greater involvement in the work together with some understanding of sociology and social psychology. Moreover we hope after a period to gain a fairly objective evaluation of the possibilities and the problems of a psychiatric hostel. A further benefit is the similarity of approach, background and education between the residential staff and those responsible for its administration. Finally, there will be a considerable saving of money. Although it is only weeks since the new arrangement was introduced there are certain changes that give cause for optimism.

In the past residential staff had maintained a well defined social distance between themselves and the residents. The Warden and his wife had invariably eaten in their own room, waited on by residents, or if this was not possible, by the cook. There was good reason to believe that face to face contact between staff and residents was kept to a minimum. Real involvement with residents only occurred at times of crisis or when the Warden exercised his disciplinarian function following some infringement of the rules. Efforts by the Chief Mental Welfare Officer to organise group meetings of residents and staff, to encourage group cohesion and to examine organisational and inter-personal problems proved abortive for several reasons. Despite all attempts, residents but more especially staff, failed to understand the purpose of the meeting. Although it was intended to allow and encourage residents to air their views and voice their complaints, in practice they spoke little of their own problems and anxieties, but echoed almost word for word the problems that were occupying the minds of the staff.

The present regime has started with a refreshingly new approach. They have of course the advantage of comparative youth and a secure social position – both are graduates with recognised professional qualifications. They have therefore no need crudely to foster a position of social superiority to the residents. The introduction of a weekly meeting of staff and residents is under way, although much re-assurance will be needed to overcome the traditional defensive attitudes that prevent effective communication. Perhaps more important than the formal group meetings are the joint engagement in theatre and cinema visits, and social activities in which friends and relatives of the residents are invited to the hostel. The involvement of residents with the help of the staff, in such do-it-yourself projects as making simple coffee tables and soft furnishings will, we feel, help towards creating the atmosphere of a 'home' rather than institution. As the internal organisation of the hostel improves, there is greater urgency required in obtaining suitable lodgings. It is crucial that we avoid the mistakes of the past when fairly sophisticated arrangements for obtaining necessary places for residents in the mental hospital, went hand in hand with very primitive arrangements, if any, for their discharge and re-establishment in the community. The psychiatric social worker now resident at the hostel is organising a search for sympathetic landladies. This, together with a recently approved scheme for a house to be converted into self contained flats, should provide a sufficient range of facilities to enable efficient and proper use to be made of the available residential resources.

If all goes well with the new arrangements at Kersal House more attention will have to be turned to the hostel which caters predominantly for mentally subnormal people. At the present time it is almost impossible to recruit assistant wardens and it may well be that a complete re-appraisal of how this hostel is organised and staffed will have to be made.

### The Chronically Disabled Psychiatric Patient in the Community

It has long been recognised that most urban areas harbour a considerable number of people who, because of psycho-social difficulties, are seriously handicapped in their social functioning and for one reason or another are receiving little or no specialised help or support. In many cases help is not unavailable, but because of the nature of the disorder, it is unacceptable to the patients or their relatives.

To increase our understanding of the size and nature of the problem, it was decided to add to an existing register compiled in 1964 which relied on the memory of mental welfare officers, by writing to each family doctor in the City. We requested that each general practitioner complete a short form, giving the name and address of any, who by reason of a psychiatric or nervous disorder required further help or services, whether or not they were currently under treatment. It was also pointed out that the information was necessary for future planning of the psychiatric services in Salford. Over sixty doctors were circularised : one doctor returned the form, with the name of one patient who was already known to the Mental Health Service.

Many conclusions might be drawn from this experience, but certainly such methods of eliciting information are ineffective.

A more successful method of discovering people who are obviously handicapped was introduced in March, 1965. A number of questions was added to the pre-coded schedule that is completed by each mental welfare officer on all episodes of mental illness referred to the service. The questions were aimed at eliciting the duration of the patient's social disablement arising from a psychiatric disorder. Disablement was defined for this study as a person of working age who for all practical purposes has been continuously out of work for over one year, or in the case of a married woman, who had been unable to perform her usual household duties over the same period.

| | Men | Women | Total |
|---|---|---|---|
| Total number of Patients referred during the year | 224 | 348 | 572 |
| Average number referred in any nine months | 168 | 261 | 429 |
| Total number of Patients referred during the nine months the scheme was in operation, who were disabled, as defined | 48 | 57 | 105 |

The figures reveal that practically one in four of all patients referred to the Service had been socially disabled for over a year; in many cases it was from five to ten years. Clearly there is much work to be done with this

important sub-group of the Salford psychiatric population. It is to be hoped that in the future a proper analysis will be possible. A retrospective study to investigate the response of these patients to hospital treatment and community services and support would help us to establish priorities in the planning of future psychiatric services in the area.

### Records

1965 saw, for the first time, the introduction of a reasonably efficient, workable method of record keeping. In the past an index card with the name and address of the patient, the name of the social worker, and the case file number was filed alphabetically. The presence of this card showed that the case was known to the Mental Health Service, and the case record could be found by reference to the number on the index card.

This system neither readily revealed whether a case was under active care or not, nor how many cases were being dealt with at any particular time. As the service has expanded and new fields of work have been accepted it has become increasingly important to have a recording system appropriate to the existing and future needs of the Service.

The new system readily reveals the following :–

1. The number of cases under active care by the Mental Health Service at any particular time and the number of cases closed during the year,

2. Those cases which are on the up-to-date mentally subnormal register,

3. Psychiatric out-patient or child guidance clinic cases which have not been formally referred to the Mental Health Service,

4. The psychiatric case load of each Mental Welfare Officer.

## TRANSPORT

In 1965, as in previous years, conveying trainees and work to and from the centres has raised problems.

Despite the excellent work of the large special sitting-case ambulance taking children to the Broughton Junior Training Centre and Special Care Unit there were several vacant places there because of insufficient transport and the inability of parents to take children to the centre themselves. Two journeys, morning and afternoon, were needed for children currently attending, but a third would have reduced the time spent in the centre beyond reasonable limits. Moreover, so many individual requests were received from parents and and other interested parties to have collecting points close to their homes, that all but a very few special cases had to be refused, and a limited number of stops arranged, to achieve a satisfactory schedule for the vehicle.

Conveyance of goods to and from training centres has been dependent largely upon the firms concerned, who could not always provide vehicles when needed. This sometimes left the centre short of work.

Fortunately the prospect for 1966 is better.

In December, 1965, the Manchester Branch of the Variety Club of Great Britain handed over to the Mayor of Salford (Alderman Miss Bertha Davis), acting on behalf of the Health Department, a twenty-seater coach to be used specifically for conveying children. This vehicle will augment the ambulance service to Broughton Centre, and should increase the time children spend there, while reducing the time of travel. Also in 1966, a new Mental Health Section Sitting Ambulance/Van will replace the bus used for adults and older children, and will help to regularise the collection of work from local firms.

## SOCIAL CLUBS

### Stepping Stones

The Club has continued its mixed programme of regular activities – dancing, darts, dominoes, etc. – and special entertainments. These have varied from concert parties to choirs, beat groups to Scottish dance teams, and the Club is greatly indebted to the many people who have given so willingly of their time and talents. There has been a relatively small change in membership over the year with few new faces. In part, this reveals poor liaison with the hospital in canvassing new members and in the coming year we intend bringing a group of people to the Club every Tuesday evening, whilst resident in Springfield Hospital. We may thus introduce them to the Club's friendship and facilities at the time of their greatest need, and hope that many will continue to attend, and to benefit, after discharge from hospital. Also in 1966, residents of Kersal Hostel will be encouraged to attend the Stepping Stones Club.

Club members at present fall into two broad categories. The first, committee members and their friends, consists of former patients and their relatives who, having achieved a 'management' role, assume a 'staff' status. They run the Club for the other members in much the same way as other voluntary workers in the social services, and gain similar satisfactions. Because of their own experiences, and having been ordinary members before joining the committee, the intensity of their involvement brings with it consequent benefits and dangers. The second category consists essentially of handicapped persons, some elderly, some resident at our hostels, some having experienced many years of institutional life, some, whilst living in the community having never achieved much in the way of social contact.

Previous Annual Reports have lauded the democratic constitution of the Club and its success in terms of member participation. During the past year one of the dangers of a totally member-run Club became apparent. The Club being predominantly intended for psychiatric patients and with no staff member on committee, it was always possible for one or more members during periods of illness or special stress, or because of personality features, to assume an autocratic role. Other committee members are mostly ineffective in handling such a situation because of their own inadequacies, and the powerful ideology of the Club which commits members – and especially committee members who are working for the others – to an unusual degree of tolerance of all abnormal behaviour. There were signs during the year that the most important function of the Club – to encourage real social interaction and experience in relationships – was in jeopardy, and although no drastic action proved necessary it is clear that staff members must take a more active part to ensure the collective status of the elected committee.

### The Cleveland Club

For some years it has been realised that existing clubs did not meet the needs of a small but important section of Salford's psychiatric population. The group is not clearly defined, but in general consists of younger, more intelligent people of slightly higher social status. Most of them have received treatment in the general hospital psychiatric ward or out-patient clinic, rather than the mental hospital itself. With these patients, it is realistic to hope to develop group identity and activity through group discussions, since they are on the whole articulate. To meet this need a new club is to be opened at Cleveland House, one evening a week.

### The Crescent Club

The Crescent Club for subnormal adults continues to flourish. Twenty to thirty people, mostly young adults sixteen to thirty years old, gather weekly to join in the activities. Groups engage in woodwork, painting or various games, with the aid of some members of the training centre and social work staff. Occasional entertainments in the way of shows and films break the routine of activities. This Club serves an invaluable purpose in furthering the social training programme of the training centres. It is a pity that there still many young subnormal adults, attending our training centres or not, who would greatly benefit from the club, yet do not come. In a number of cases parents are reluctant to allow them to come alone, if unable or unwilling to bring them and collect them. It is quite impossible for the local authority to provide transport to and from the Club. Other parents appear unhappy at the low social and intellectual status of club members, never having accepted perhaps the degree of mental handicap of their own child. This reinforces our realisation that in the subnormality field careful education of parents is indispensable if social training is to be effective.

At the Club it is noticeable that young people on our staff have a great deal to offer in relationships and in activities, and it is hoped in 1966 to have the added help of at least one young person from International Voluntary Services.

## REVIEW OF SERVICES FOR THE SUBNORMAL

In the Annual Report for 1964, it was noted that a revision in the filing system had brought to light a number of anomalies and errors of classification. Some corrections were made, but it was decided to review the whole of the Subnormal Register and to create a simple written register for the daily use of the Department. The problem remains that of classification in the borderline group. A large number of such people, we discovered, had not had any contact with the Department for many years. Many of these were young adults who had been referred – automatically before 1960 – from special schools. After a variable period of care, supervision and guidance, the social worker concerned had felt that they no longer needed him, or that he could be of no further help. In many of these cases, however, he did not formally remove them from the register. It is difficult to make the decision to do this at any one point, since developing independence is essentially a matter of maturing over the years. Reviewing the case files, people not seen for several years fell roughly into two groups. First were those whom the social worker had

consciously left alone feeling that they are now sufficiently independent to stand on their own feet. These can be viewed as having been virtually discharged – though their names were not formally removed from the register. We have taken the opportunity now of removing their names, and these appear in the tables as a separate group.

Second were those who seemed to be in the middle of some stress period or crisis, certainly not obviously having achieved sufficient independence to be discharged, yet who were not visited or seen for many years. The reasons for this are not clear. Some would no doubt be due simply to pressure of work upon mental welfare officers, but in many cases, the workers must have felt that whilst there were problems in plenty, they were unable to help any further, and therefore felt it useless to visit. In some cases intended follow-up later was never successful; in others all visitors were unwelcome.

This very interesting group of people, approaching 100 in all, could not simply be removed from the register and forgotten. We have, therefore, instituted a research programme to follow them up and discover if they still need help, or to what degree they have "drifted into normality". This will be reported on next year.

We have also reviewed all subnormal persons in hospital care at the end of 1965. This is not as easy as it might sound since Salford patients are distributed throughout the kingdom in 26 separate institutions. We sent to each hospital a list of Salford patients we believed to be resident there, and asked them to check this and alter accordingly. For the past few years we have dealt almost exclusively with Brockhall Hospital. Communications with them being good, few discrepancies were discovered. But for other hospitals this was not so. In many there were a number of deaths, discharges to other areas, or transfers to other hospitals, that we had not recorded. Some people obviously did not 'belong' to Salford any more, and some we did not know, should be our responsibility.

This exercise of review was undertaken in order to make and keep our register a realistic measure in readily accessible form of all those subnormal persons belonging to Salford who are currently in need of care or help of some sort. If services are to be organised and planned nationally, if people needing help are not to be lost, yet social workers' time is not to be wasted, this is essential. When we have completed the total review, all remaining on the register and living in the community will be allocated to a social worker. We will be in close contact with many through training centres, hostels and clubs: others requiring close contact will be visited according to their needs. A final group do not like being visited, or are well cared for by families who will seek help when necessary, and contact will be maintained by a yearly letter. This is an attempt to increase the efficiency of the department by cutting down routine visiting without abdicating from our responsibility.

The number of cases for 1965 is similar to previous years excluding 1964. The high figure of 1964 was, in fact, due to catching up on previous years omissions in the 15 – 19 age group. But the large number referred in the 0 – 4 age group, both in 1963 and 1964, was due to a change in policy on behalf of the maternal and child health services with the appointment of a new senior assistant medical officer. Though this continued trends of

previous years, to some extent it swept clean, and the numbers in this group are therefore much reduced in 1965. At the same time the 15 – 19 age group was also reduced in 1965 probably because of the excellent employment situation in the area. Most of this group are young people having left special school and been unable to obtain stable employment.

In the last Report we discussed the problem of the 0 – 4 age group. Appendix VII throws more light on this. Referral to Mental Health is after referral to Maternal and Child Health, but this division is not very realistic now since the Child Health Officer has now taken on the medical supervision within the Mental Health Section of this group of children, the Infant Training Centre and the Special Care Unit. This integration has been very advantageous in the work: it also makes the referral differences almost meaningless. It can be seen, (Appendix VIII B) that the service as a whole received 14 cases under five years, eight of them under one year and five under one month! This also continues the trend of previous years.

**Training Centres and Training**

The adult training centre differs fundamentally from the junior centre in having a less restricted clientele, and the conflicting needs of sub-groups amongst the trainees gives rise to policy problems. Within the last five years, most adult training centres have become industrially orientated, taking in contract work from local firms and cultivating a workshop atmosphere. In many ways this is a great step forward. For those subnormal persons who are eventually to achieve ordinary employment, work training is essential. This includes not only training in specific industrial tasks, but familiarisation with workshop atmosphere and routine, and the discipline of regular hours. Such training need not be restricted to the centre. In Salford, suitable trainees attend local firms half a day a week for real industrial experience, and others assist in the Health Department Dining Room for experience in kitchen work. These arrangements have proved very helpful in placing trainees in suitable jobs.

A further benefit of a work situation in the centre is that it allows the trainees better to feel and to find the dignity of adult status. It helps to banish the idea and name of "school", firmly fixed in many parents' minds, and trainees and their families can readily see themselves as going to "work".

Conflicts arise, however, when we remember that inevitably, a large proportion of our training centre population is never going to work in the open labour market. This group stay the longest at the centres. It is certainly good that they are able to see themselves as coming to work, but in many cases we are deluding ourselves if we think we are doing much more through the actual industrial activities, than occupying them usefully. And for this group industrial contract work may or may not be the best form of occupation. There is a danger that the interest of contracts may be allowed to take precedence over the interests of the trainees, especially if the centre is a small one. Since late maturing is characteristic of subnormal persons generally, many of the most severely handicapped, having reached the age of 16 and been transferred to the adult centre, yet need provision for creative play as well as work routine.

In the Annual Report for 1964, Dr. Susser discussed the conflicting goals in day centres and hospitals. The dangers inherent in a simple and essential care-taking role can be avoided, by giving priority in the hospital, to therapeutic goals; in the centre to educational goals. This is easily recognised for those who will eventually work, but for others it can only be so if priority is given not to industrial training, which is in any case inapplicable to their situation, but to social training.

Social training should undoubtedly be the most important aim of the adult training centre. Relatively few trainees will achieve industrial work, but all must live in society; even those with employment potential must be socially competant if they are to realise it to the full. Many subnormal adults having suffered from a life of over-protection lack social skills below their true potential, and many maturing late are able to achieve a certain measure of independence only as they enter the late teens or early twenties. The junior centre must begin training, but a continuous process and consistent pattern of training is needed throughout any individual's training centre career. Not all training is social training, but all training in centres should be given with an eye to the developing social competance of the individual trainee. A co-ordinated approach, spanning all the centres, is perhaps only possible through a centrally based education officer, in an advisory and supervisory role to the whole training centre programme.

Gunzsberg, in his recent papers, has described a residential "finishing school" for subnormal adults and emphasised the importance of social training. The lack of a true control in a non-residential setting makes it difficult to evaluate his claims: the improvement in social competance shown by his trainees is more readily attributed to the social training programme than the mere fact of residence. Such a programme in itself is, however, of undoubted value, and it seems to us likely that retention will be better if training is given in the local, known surroundings. Since transferability of knowledge and skills is a sophistication of intelligence many subnormal people lack, a pragmatic training closely related to particular local and individual needs seems for many a more realistic goal than the attempt to cultivate social skills, as it were in the abstract, in a strange area and a residential setting.

Certainly the same degree of training should be given to trainees at home, as Gunzsberg gives to those in residence. Though such intensity may be impossible training can be given over a longer period and, whereas in a residential course, parents and day centre staff are untouched, who must care for these trainees (for many years) on return, a social training programme within the home and day centre setting can carry both parents and centre staff along with it. Indeed, in our experience, it is as important to educate parents of subnormal children and adults as the trainees themselves, if permanent social skills are to be developed. The team available in the community services for the subnormal, centre staff, education organiser, social workers and doctor may all play a part in educating parents and relatives, who can themselves be involved in aspects of the social training programme such as club activities. The work with parents is often the most difficult, frustrating and time consuming, since their handling of their child is bound up so closely with fears and guilt often unresolved for many years. Out of their own care and concern many are reluctant to see the child they have accepted as handicapped, now adult, taking those risks both physical –

mostly on the roads, and emotional – in experiencing new relationships outside the understanding and acceptance of the family, necessary for development of social skills and personality growth.

Much social training, as Gunzsberg has shown, must take the trainee out of the centre. In Salford the appointment of an education organiser and the purchase of a mini-bus vehicle allows more flexibility of approach and variety of programme. But centre staff themselves must see this as fundamental to the purpose of training centres, junior and adult.

The education organiser has three main areas of operation. He is able to link all centres in a unified programme, and to facilitate transfers from one to the other. His principle educational role will be to offer the training centre staff, of his understanding, training and experience, that they might increase their competance in a teaching position for which so few, particularly in adult centres, have received training. In the absence of opportunities for formal training, such in-service training is essential. But the effectiveness of the education organiser, as an outsider to the centres, and often threatening to insecure centre supervisors, may well depend upon the demonstration of his skills alongside centre staff. This third role will therefore be akin to that of the traditional remedial teacher, but much broader in scope. He will be able to spend time not only with individual children in the centre, but groups in and out of the centre. He will be concerned to demonstrate not only the development of intellectual potential, but also the cultivation of social skills.

With any special emphasis in training, it is advisable to have some measure of individual needs and results. We are therefore using Gunzsberg's P.A.C. social competance charts together with the Vineland Social Maturity Scale; and hope to obtain some insight from these into the effectiveness of training procedures.

Unrealistic attempts to teach reading and writing in training centres have long been abandoned. Nevertheless in the more able trainees, particularly in adult centres, it is not entirely unrealistic, and reading and writing skills open up such vast possibilities, previously unattainable, that we should try to develop these whenever possible. For many this must be restricted to the social sight vocabulary as used by Gunzsberg; but, whatever the individual goal, it is unlikely to be achieved unless teaching is provided for adults. In Salford our "evening class" system has worked admirably, but there is a much greater demand than we can handle, not only from our adult trainees, but from others of fairly low intelligence now working, having usually attended special schools and only in having achieved some degree of maturity being motivated sufficiently to benefit from reading and writing instruction. We feel that the "evening class" system is better for trainees than having classes in the adult training centre itself, during 'working hours'.

## JUNIOR CENTRES

The new junior training centre building has been started during 1965, and we look forward to moving from our admittedly inadequate present accommodation. New buildings, however, will not solve all our problems, though they will be partially eased by having more space and a single unit for children.

The mentally handicapped fall roughly into three groups. Those who will become essentially self-supporting after suitable special education, training and guidance, do not usually come to the Mental Health Department as children. Those who, with special training and some degree of permanent supervision and shielding, can take a real place in the community, are the main responsibility of the training centre system. Those whose intellectual or multiple handicaps are of such degree as to preclude all possibilities other than permanent total care, are largely reliant upon hospital services, but as children may be contained within a local authority Special Care Unit.

The Broughton Junior Training Centre, taking children up to seven years of age, and the Special Care Unit, have now been full to capacity for a number of years, and with an ever-increasing waiting list, pressures from below are mounting. The Junior Training Centre children move on at seven to Seedley Junior Training Centre, but the Special Care Unit children remain. We are now facing a crisis situation in the Special Care Unit as the oldest children achieve 16 years, and it is opportune to review the whole field. Our immediate problem is to balance our desire to provide continuing care for children we have had for many years, and whose parents wish to keep them at home, and our knowledge that doing so will preclude further admissions of infants. We firmly believe that special care must be provided in the earliest years if any progress with habit training is to be made, and if the families are to be helped to cope with their children at home, and we would not like to see the age of admission raised because of silting up. What then will happen to these children at 16? The general concensus of opinion throughout the country, strongly backed by the Ministry of Health, is that provisions for such handicapped people are the responsibility of the Regional Hospital Board. We accept this, not to avoid attempting to make provisions ourselves, but because it seems a rational and right division of responsibility. Though care of multiple-handicapped children can be seen to have a large 'training' element, care as adults is predominantly nursing and minding. If then, they are to be removed to hospital care at 16, is it right to encourage parents of grossly handicapped children to jeopardise or blight their own family lives for 16 years, by providing special care in the community at all? This must be considered a serious argument, but it ignores the fact that many parents do sincerely and deeply wish to keep such children at home, and in the absence of the hope of normal life, to surround them with as much love and attention as possible. In some areas parents organisations have themselves provided local special care day services, in the absence of local authority units, to enable their children to stay at home. Some parents even retain their children at home full-time, in spite of the incredible stresses this provides. We must respect the real wishes of parents, and not arrogate to ourselves the decision as to what is best for them.

Yet how much of this derives from the knowledge or assumption that the only alternative is very inadequate hospital care. In Salford, parents must either keep their children at home or send them to Brockhall Hospital, thirty miles away. They can visit rarely at such distances, and often do not like the large institution. The hospital itself has great difficulty in attracting sufficient good staff and many parents, knowing this, must feel that there is no real choice. Community care has now been successfully 'sold' to the general public, and parents do not want their children 'put away' – a phrase still much used by the older generation – nor do they want people to think they are doing this.

In every individual case it is of the utmost importance that no unfair pressures be put on parents, either to send the child to hospital or to keep him at home. The highest degree of social work skill is called for in this situation. Yet unfair pressures are inevitable, and strong unless there is real choice for parents of a full range of services. At present we are just postponing the decision until the child has achieved the arbitrary age of 16, by which time he is much more difficult to handle at home, yet the decision to part is much more agonising. This is true at present for Salford, and the only way out of our dilemma is the joint provision by Local Authority and Regional Hospital Board of a local day and residential special care unit, accepting all ages and all minding, nursing and training demands, and allowing any combination of day attendance and residence that parents may require. Anything short of this must be considered very unsatisfactory, and we feel we should work with all due urgency towards this goal.

## THE ROLE OF THE MEDICAL OFFICER IN MENTAL HEALTH

In Salford it has been a long tradition that medical officers be involved extensively in the mental health services. Nationally, progress in community provisions has been due certainly as much to certain foresighted Medical Officers of Health, as to psychiatrists themselves, yet many areas still feel unable to allow full time involvement by a medical officer in the expanding services. It seems pertinent then to ask what contribution a doctor makes in this situation. The administrative demands need be few, if good non-medical administrative staff is employed. Contribution to policy determination, with chief mental welfare officer and consultant psychiatrist, will depend upon his individual experience and status, as will his value in terms of health education, public relations and liaison with hospitals, general practitioners and other agencies – functions sometimes best performed by a doctor.

His training as an epidemiologist certainly allows the medical officer to conduct research in the setting of a practical social work agency. It is a criticism, variously valid, of much community research that it is conducted in vacuo by academies not in touch with the practicalities of the field workers. Social work departments must accept basic operational research as an essential part of their work – at least to discover how services offered meet, or do not meet, active needs and to assess future demands on services in order to plan rationally. But the epidemiologist in this setting has opportunities for fundamental research not easily available to hospital psychiatrists, and the experimental nature of many of our new facilities demands that we explore all possible avenues.

Administration and policy, health education, public relations and research; these are routines for the public health doctor. But beyond this, what is the role of the medical officer in the developing psychiatric services of today? In the following pages we discuss the possibilities as they appear to us, in the light of our particular experience in Salford and taking into account current trends in associated fields.

### Mental Illness

Most psychiatrists in this country have traditionally based their work upon the mental hospital. With a gross andchronic shortage of doctors working in psychiatry in many areas, the demands of hospital out-patients and in-patients has permitted little involvement in the community services. The 1959 Mental Health Act placed the responsibility for developing community services on the Medical Officer of Health, and few psychiatrists were actively involved in local health departments. Many advances in community psychiatry, therefore, developed outside the immediate orbit of the hospital psychiatrist, and although in many areas he now has consultant status to the local authority the time which he can give remains very limited.

Yet in Salford, even in 1959, 25% of patients referred to the Mental Health Department were handled by community services only. By 1965 this had risen to 34% (Appendix II B) and only just over half the patients referred were passed on to the care of the hospital psychiatrist. Moreover all hospital discharges are notified to the Mental Health Department, and many patients spend a much longer period under our care, than they do under the hospital. It is not even realistic to think that people are "ill" while in hospital, and reasonably well when back in the community. Hospitals are still short of beds, and most patients spend only a short time on the ward. For some patients the available hospital facilities are not the most appropriate: others are admitted primarily for social reasons, and whilst they are in hospital, the family may require more attention than the patient. The large number of chronic schizophrenic patients, senile and subnormal people who constitute the bulk of psychiatric referrals requiring long-term care, may spend occasional and even repeated short periods in hospital, but the community is now their normative environment and the community services must cope continuously with their needs over many years.

Posing a slightly different problem is the group of patients constantly moving in and out of hospital, for whom continuity of care is of the utmost importance. The degree to which they require hospitalisation may depend upon the efficiency of local authority services. This, with the relatively recent expansion of community psychiatric services, makes it appear strange that in many areas medical involvement is so little. As further progress continues over the next few years it is going to appear even more strange if the majority of psychiatric patients for most of the time are handled in therapeutic and rehabilitatory institutions, with little more than an occasional cursory glance from the still hospital-based consultant psychiatrist.

In Salford medical staffing of the hospital psychiatric services has long been critical and there appears little likelihood of improvement in the foreseeable future. There has for some time been no full-time doctor in the mental hospital Salford 'unit', other than the consultant. A hospital service run on part-time junior staff, with the assistance of a handful of G.P's, cannot do

more than cope with physical treatments and unavoidable routine. Community aspects must of necessity be virtually ignored and the time, energy and zeal to break new ground, establish experimental procedures and promote the spirit and atmosphere of hope and enquiry is inconceivable. The general hospital psychiatric unit has been better able to attract a succession of registrars, but in few regards can the medical situation in the hospitals either at present or in prospect, be considered satisfactory.

During 1965, the Salford Mental Health Department has also suffered a considerable reduction in doctor-time. Dr. M. W. Susser left us after many years of stimulation and drive, having been responsible in large part not only for the actual advances in community facilities, but also for the progressive outlook and flexibility of approach essential to rapidly expanding but incompletely understood and therefore experimental, services. To a large extent charismatic, his most important influence over the years has been in the realm of idea and ideology.

Dr. A. G. M. Wiseman also left us in 1965 after many years of practical work, largely in the subnormality field, leaving us with only one doctor working within the mental health department. Moreover it is increasingly difficult to fill vacancies for assistant medical officers, and those with psychiatric experience are rare indeed. And we know that the general shortage of doctors will continue for at least ten years.

To some extent the hospital staffing difficulty has stimulated co-operative enterprise good in itself though giving rise to other problems. Recently begun ward meetings of staff and patients in the mental hospital have been 'run' and supported more by the local authority social work staff than hospital staff in the absence of a doctor able to give the necessary time. The joint appointment of another P.S.W. concerned solely with Salford Patients should reduce the patients' demands for a doctor to be available for interview on the ward. The new group opened at Cleveland House has accepted in-patients from the Hope Hospital psychiatric wards across the road and group discussions as well as individual interviewing and various creative activities are being undertaken. The same thing applies to the new 'Monday Club' at Cleveland House which one evening a week has attracted in-patients from Hope Hospital as well as others living in the community. Similarly it is hoped to take in-patients from Springfield Hospital to the Stepping Stones Social Club on Tuesday evenings, as soon as transport can be arranged. It is also hoped to explore the possibilities in 1966 of Dr. Fryers being jointly appointed to the hospital psychiatric services as well as the Salford Mental Health Department. Such developments are discussed more fully elsewhere.

These are exciting developments in community care, and in co-ordination of psychiatric services. Yet their additional demands on an already busy local authority staff must limit their effectiveness and their potential. Moreover, to some extent they have arisen to fill gaps in the hospital services associated with the shortage of doctor-time. We must therefore consider the possibilities for the future in this light.

In Salford several avenues are open to the family doctor requiring a psychiatric opinion and psychiatric services. Out-patient clinics are held at both general hospitals, but with the present shortage of hospital staff, patients may only see a G.P. clinical assistant. A domiciliary visit by the consultant

is readily available, but is inordinately time consuming, and general practitioners tend to use this merely to obtain a quick decision, particularly regarding hospital admission. Otherwise, the family doctor refers directly to the local authority Mental Health Department for social-work help. The Mental Welfare Officer may then discuss the case with the Consultant who usually attends the weekly case-conference. But the Consultant is not always available, and inevitably the Medical Officer, working with the social workers in the local authority team, is increasingly drawn in for clinical assessment of cases. This is true not only for those patients attending clubs, day centres and hostels, and for those picked up by the police, but also for people at home, where hospitalisation is being considered and where compulsory admission may be needed. As Social Workers and G.P's work closer together – and a 'Health Team' Family Medical Service will be initiated in 1966 – out-patients will almost certainly be increasingly by-passed, the mental health social worker (alias the Mental Welfare Officer) will be involved in initial assessments of more and more patients, and the local authority doctor working in mental health will be forced into clinical psychiatry.

In teaching hospitals, in the centres of the large connurbations, in southern seaside resorts and perhaps newly-built mental hospitals, it may be possible to view medical staffing over the next ten years with optimism. In the vast 19th century mental hospitals of the decayed industrial north-west there seems little hope. It is possible for them to continue in the old way on a thread-bare part-time staff, but it may be necessary ultimately to face the simple fact that there are no junior doctors for the mental hospitals. It may be more realistic now, to accept this and to re-think psychiatric services accordingly.

In this situation therefore, the local authority is the centre of psychiatric activity, not the mental hospital; the community setting, not the distant institution. Since both aspects of the psychiatric services serve the same people, a unified approach is the obvious ideal, in which the hospital is not separated out, but is seen as providing certain special facilities within the total system of comprehensive care. This implies also a unified staff. In some areas mental hospital nurses have been drawn into community activity especially in terms of after-care. In other areas, notably Croydon, psychiatric social workers are employed jointly by hospital and local authority and are available to patients in both settings. In Salford we have started along this road. But the doctor remains the focal member of the psychiatric team and has peculiar special advantages as such in the status and role accorded him in our society. He cannot therefore ignore the unifying processes at work in the mental health field, nor, in places such as Salford, can the hospital psychiatrist and the employing authorities ignore the writing on the wall.

It is therefore increasingly evident that medical staff in psychiatry, at all levels must eventually be jointly appointed by local authority and Regional Hospital Boards to a unified psychiatric service serving a particular community. The inability of the hospitals to attract doctors, the increasing complexity of community services, the demands of patients for continuity of care, the growing concern for preventive measures, and the development of comprehensive appointments for other members of the professional team, all point firmly in this direction.

The implications of this development require that Regional Hospital Boards and local authorities work closely together – perhaps far more closely than is now practice. Since the aim is a comprehensive and unified service for a given population, hospital facilities and personnel must be married to local authority areas. In Salford, for some years now, there has been movement in Springfield Hospital, which serves a multiplicity of local authorities, towards separating out a 'Salford Unit'. We have during this period dealt almost exclusively with one consultant in the hospital and one ward is used only by Salford patients. But the progress has been very slow, especially in terms of junior medical and nursing staff. With the likelihood of radical changes in local authority boundaries in the next few years, it is to be hoped that Regional Hospital Boards will take the opportunity of linking their facilities to the new local authority communities.

Other advantages from the unification of the service would accrue from such a move. The experience and training offered to doctors entering psychiatry would be comprehensive, and 'social psychiatry' would achieve its proper status, the concern of the general psychiatrist as important as clinical considerations. Moreover, the opportunities offered by such a service, for the in-service training of all members of the psychiatric team, through working closely together in all fields of activity, would be unsurpassed. It is also possible that posts at senior house officer and assistant medical officer of health level, could be admissible psychiatric training for general practice where knowledge of the services is as important as possession of psychiatric skills, and doctors entering other specialities, and at the same time provide much needed junior medical staff.

Finally, but of fundamental importance, joint appointments within a comprehensive and unified psychiatric service are likely to prove far more attractive in these days of change, expansion and experiment, than the hospital posts of the past. When all that is said publicly on mental health topics emphasises the development of community services, the running down of hospitals, even the reactionary motive of the large institutions themselves, young doctors are unlikely to be much attracted into psychiatry. The demands for psychiatrists will continue to increase: it is of the utmost importance that young men with a broad vision and balanced view should be attracted to the service, and that then, they should receive the broadest and most balanced training and experience in clinical and social psychiatry.

### Subnormality

It is increasingly being accepted that the Junior Training Centre is as much an educational institution as the ordinary school, the specific teaching varying only according to the needs and potential of individual children. The adult centre too must be recognised partly as such, providing social and work training in an industrial setting. In the organisation and running of training centres therefore, and in the planning of individual programmes, the educationist has more to offer than either doctor or social worker. If the training centre population was simply deficient in intellectual endowment the doctor would be little needed. However, this is not so. A large proportion of training centre children and adults have physical deformities and disabilities seriously affecting their performance and potential, and demanding a great deal of medical care and supervision, if they are to make the most of their limited gifts.

This demands of the doctor involvement in the training centres far deeper than a mere annual medical inspection can provide, particularly with pre-school children, and multiply-handicapped children in the Special Care Unit. For these above all, the doctor's clinical assessment upon referral to the service, is an essential beginning, and their medical needs often continue to be extensive whether they attend the centre or not. Their use of all medical and para-medical services is considerable, and for all subnormal children and adults, it is the doctor who must liaise with and organise the services of specialist paediatrician, educational psychologist, speech therapist, physio-therapist, dentist and chiropodist, as well as the family doctor and ordinary hospital facilities.

Moreover it is important that training centre staff and social workers concerned with the families of subnormal children and adults, whether they attend a training centre or not, are advised from the first of all medical considerations relevant to the training programme and family dynamics, and have medical skills and advice available at any time. Parents of mentally subnormal people need much support, and the doctor "at the training centre" who is also able to visit at home has a special part to play. The status accorded to the doctor in our society and particularly to "the specialist" is a useful tool, and it is right that parents should feel that their children, handicapped though they are, are receiving all possible care, treatment and training.

For some years in Salford, the annual medical examination has been the focal point of review of the total situation, the current achievements and the future prospects of each trainee. At this time, reports by social worker, psychologist and others involved, have been collated in planning the programme for the year. However, in 1965, a full-time Education Organiser was appointed overlooking all the centres, and he has largely assumed the co-ordinating role, as the responsibility for training centre programmes has devolved upon him. The annual review has been retained as a focal point for major decisions and to ensure that no trainee is missed, doctor and education organiser being equally involved and working closely together, but its importance is diminished. Having an educationist involved in the centres from day to day increases flexibility to cope with newly developing needs and observed deficiencies as they arise, and to change individual programmes at any time throughout the year.

Above all, services for the subnormal demand a co-ordinated approach by numerous workers, whose training, experience and outlook vary greatly. The doctor no longer claims pre-eminence but takes his rightful place as one member of the professional team.

### Child Guidance

The child guidance clinic in Britain has traditionally stood somewhat apart from adult psychiatry. Ideologically, it has tended towards analytical interpretation and treatment, whilst general psychiatry has largely been organically orientated and pragmatically administered, and where there has been any hospital contact it has been with the paediatric hospital, rather than the mental hospital.

The lack of contact with the local authority mental health department is not surprising. The clinic's highly trained professional staff acting in a consultant capacity had little in common with the old Duly Authorised Officer and his early successors, untrained and with a simple legally-defined mode of operation, who very rarely handled children at school.

These features of isolation have discouraged the integration of child guidance work with the various preventive and other services developed over the past few years. This development of community services, however, has brought with it a newly-trained local authority staff of professional social workers who can communicate with the child guidance team. The social work emphasis, and especially the influx of psychiatric social workers – once almost confined to child guidance clinics – into community mental health work, have also stimulated a new interest in psycho-dynamics, though mental hospital pragmatism and organic orientation may yet retain their dominance.

As local authority staff increases and the integration of adult psychiatric services encourages efficiency, newly-recognised demands can be accepted, especially in preventive work. Moreover, the staff traditionally in the fore-front of preventive health work, the health visitors, are also in the midst of change. Their training has now a strong psycho-social work bias, and with the rapidly expanding social work profession they are seeking new roles and a new image.

These processes have produced an atmosphere in which Child Guidance Clinic and Mental Health Staff can readily communicate, and through which expansion and integration of the Child Guidance Service becomes possible.

In some areas the implications have been accepted and a unified service developed. In Newham the Clinic Psychiatrist is also Head of the Mental Health Department, the clinic P.S.W's and departmental M.W.O's being a single, integrated body. Coventry has a joint-user arrangement for P.S.W's between the two services.

In Salford some progress has been made towards an integrated service. During 1965, the Child Guidance Clinic was transferred administratively from the Education Department to the Health Department. This move stimulated discussions between clinic and mental health staff, and one of the chief concerns has been the excessive demands which give rise to the clinics very long waiting list – often over a year. Because of the demand, and pressures from schools and juvenile courts, the child psychiatrist is forced to concentrate upon the most severe long-standing cases, requiring great resources of time and effort, often to little effect: many cases are simply too late. The total demand upon the service represents real needs in the community yet few of the youngest, earliest cases, representing the most preventive aspect of the work, can be handled unless professional staff is greatly increased. But the need is not only to increase staff, but to have an effective mechanism of screening and selection to utilise professional skills efficiently.

In previous years the work of the Child Guidance Clinic was supplemented two sessions a week by a child psychiatrist seconded from the Regional Hospital Board. This time was so limited, that he felt more useful work could be done in helping Health Visitors better to understand and aid children and families with problems, than in seeing a handful of children himself.

During 1965, however, even this was lost to us, since he left the area and it has proved impossible to replace him.

Other facilities have also been developed through the School Health Service. A School Medical Officer has for some years attended Family Guidance Clinics largely dealing with marital problems and behaviour disturbance in older children. The Enuresis Clinic has, of course, found amongst its clients many disturbed children and disturbed families. And the general child welfare clinics also handle a large number of cases which are fundamentally problems of child behaviour and psychological development, and of parental attitudes.

All these facilities to a varying extent act as screening agencies for the Child Guidance Clinic, but in order to extend the service further in the direction of known demands, a team consisting of Health Visitor, Psychiatric Social Worker and Medical Officer in the Mental Health Department, commenced work in 1965 to act as a Child Guidance Screening Clinic, and to handle those cases which were felt not to require the most specialised skills. The intention was also, to concentrate upon early stages of disturbance particularly in pre-school children and their families; to attempt, that is, true preventive work.

Since most case finding is done by the Health Visiting Service, the Health Visitor of the team has acted as liaison officer and has discovered initial basic information pertaining to the case, before passing it on to the doctor and psychiatric social worker. Consultation is available from the Child Guidance Clinic Psychiatrist and Psychiatric Social Worker, the Hospital Paediatrician and the Department's Educational Psychologist.

This 'Family Problem Clinic' commenced towards the end of 1965; little but initial impressions can be given, therefore, of cases referred, but most are relatively recent behaviour problems such as lying, stealing and uncontrolled aggression, or anxiety and lack of self confidence, in pre-school and early school children. However, general impressions are of four characteristics applying to most cases :–

1. Anxiety in the mother is prominent as a cause of referral, whether it relates realistically or not to the child's behaviour. What may be almost universal and perhaps 'normal' acts of aggression and deception may give rise to undue anxiety in the mother, often with a background of many other domestic problems;

2. Children referred tend to be above average in intelligence, often active, lively, interested children. This may be related to the demands made by more intelligent, more middle-class parents who have greater aspirations for their children and less tolerance of aggressive behaviour. But such children also need more understanding and active handling by parents, and need more varied outlets for their vigour, and in overcrowded and restrictive homes, are more difficult to rear than dull and passive children;

3. There is an obvious lack of involvement and interest on the part of fathers, especially noticeable of course, in boys at school. It may be that our health education forces should be brought to bear upon our

community, to emphasise the need for fathers to be engaged actively in the rearing of their sons, and to provide a more positive and vital image of manhood for them to follow. The cultural breakdown associated with large-scale re-housing, may provide an opportunity to reinforce the positive aspects of conjugal roles;

4. A strong characteristic, related to the last paragraph, and noted over many years also in the child welfare clinics, is the low level of communication within the family. Mothers and fathers rarely talk seriously to each other about anything: children are not brought into discussions, and verbally are often treated summarily and superficially. This appears to be of fundamental importance and it often seems that if we could stimulate real, deep communication within the family, many problems would resolve themselves.

There is undoubted need for a counselling service of this sort. Even at its lowest, the relief of anxiety may be truly preventive of later, more serious problems and relieve many demands, ill-understood and unmet, on the general practitioners and other services. And the needs are often much greater than this. But in providing therapeutic counselling time is needed; it cannot be much hurried if it is to be effective. This means that a small staff can accept only a small case load. It is however another step towards a comprehensive integrated and preventive mental health service which is our ultimate aim, and is, we feel, one of our major growing points for the future.

**Social Work**

The greatest change effecting local authority mental health departments, over the past ten years, has been their re-orientation from a legally defined specific function to full-blown professional social case work. This process is variably incomplete throughout the country, but in Salford we have been fortunate in being able to move a long way towards the final goal.

Nationally the inevitably concomitant of this change has been the multiplication of training courses available to potential social workers, which, in spite of the desire to give formal training to established and experienced people already in the field, have accepted many who are young and inexperienced. If the social services are to expand, this must happen, but qualifications in academic and practical social work, degree or diploma, are but a beginning, a foundation upon which we may build.

Not long ago, many candidates for the post of mental welfare officer were mental hospital nurses, who often had great personal problems of re-orientation, but whose medical knowledge was of real benefit. The modern young social worker has no knowledge of medical matters at all. Indeed he may even have no biological insights beyond the most superficial, having never studied biology even at school. In a psychiatric agency this can be a serious handicap to understanding their clients, both mentally ill and mentally sub-normal. There are anatomical, physiological and pathological implications of all mental disorders, which may be causative, may hinder recovery or re-habilitation, or which may add a further dimension to the needs of the client. It is difficult to help a family to accept and live with a disabled member, if the social worker does not appreciate the true nature, degree and implications of the disability. Especially is this true of the mentally handicapped child and his family, for whom medical aspects often assume great importance.

It may be that generic social work training should include far more biological and medical instruction, but pressures on the syllabus are many and the current situation must be handled first. The gaps must be served by in-service training, and it is necessary for the doctor in the mental health department to be available for discussion of cases, and to be involved in the regular teaching seminars of the department. The need is not only in terms of psychiatric symptoms and syndromes, normal and aberrant child development, but also of simple anatomy, physiology and general medicine.

If in the long run, the newly trained body of young social workers is to develop into a mature and informed body of professional counsellors, in-service training, inclusive of medical matters, is essential in itself, and to enable workers to gain most from their early experience in the service.

## APPENDIX I

| Agency | Male | | Female | | Total | |
|---|---|---|---|---|---|---|
| General Practice | 79 | (35%) | 140 | (40%) | 219 | (38%) |
| Health/Welfare/ Voluntary Organisation | 14 | (6%) | 36 | (10%) | 50 | (9%) |
| Police/N.S.P.C.C. | 10 | (5%) | 12 | (4%) | 22 | (4%) |
| Hospital Psychiatrist | 39 | (17%) | 63 | (18%) | 102 | (18%) |
| General Hospital | 15 | (7%) | 9 | (3%) | 24 | (4%) |
| Relatives | 40 | (18%) | 47 | (13%) | 87 | (15%) |
| Other | 27 | (12%) | 41 | (12%) | 68 | (12%) |
| TOTAL | 224 | | 348 | | 572 | |

* These figures do not take into account the 60 referrals for Social Histories only from the Psychiatric Out-patient Clinics.

## APPENDIX IIA

All Notifications of Female Patients Referred for Mental Illness to Salford Mental Health Service in 1965 by Source of Referral and Disposal (Percentages)

| Disposal | SOURCE OF REFERRAL | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | G.P. | Health/ Welfare/ Voluntary Organisation | Police/ N.S.P.C.C. | Hospital Psychiatrist | General Hospital | Relatives | Other | Total Number | Total % |
| Compulsory Admission | 17 | 6 | 41 | 13 | 11 | 15 | 10 | 50 | 14 |
| Voluntary Admission | 28 | 22 | 33 | 14 | 33 | 43 | 15 | 89 | 26 |
| Psychiatric O.P. or Domiciliary Visit | 22 | 20 | 17 | 17 | 11 | 11 | 7 | 61 | 18 |
| Home Support (and G.P.) | 24 | 44 | 9 | 51 | 33 | 25 | 63 | 123 | 35 |
| Other | 9 | 8 | – | 5 | 11 | 6 | 5 | 25 | 7 |
| Total Number | 140 | 36 | 12 | 63 | 9 | 47 | 41 | 348 | |
| Percentage of Total Referrals of Female Patients | 41 | 10 | 3 | 18 | 3 | 14 | 11 | – | 100 |

## APPENDIX IIB

All Notifications of Male Patients Referred for Mental Illness to Salford Mental Health Service in 1965 by Source of Referral and Disposal (Percentages)

| Disposal | SOURCE OF REFERRAL | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | G.P. | Health/ Welfare/ Voluntary Organisation | Police/ N.S.P.C.C. | Hospital Psychiatrist | General Hospital | Relatives | Other | Total Number | Total % |
| Compulsory Admission | 22 | 14 | 70 | 8 | 27 | 25 | 4 | 44 | 20 |
| Voluntary Admission | 38 | 28 | 20 | 31 | 27 | 25 | 19 | 67 | 30 |
| Psychiatric O.P. or Domiciliary Visit | 16 | 14 | – | 10 | – | – | 11 | 22 | 9 |
| Home Support (and G.P.) | 18 | 37 | 10 | 46 | 46 | 48 | 44 | 76 | 34 |
| Other | 6 | 7 | – | 5 | – | 2 | 22 | 15 | 7 |
| Total Number | 79 | 14 | 10 | 39 | 15 | 40 | 27 | 224 | |
| Percentage of Total Referrals of Male Patients | 35 | 6 | 4 | 17 | 7 | 18 | 13 | – | 100 |

## APPENDIX III

Disposal of All Patients Referred to Mental Health Service 1961 – 1965*

| Agency | 1961 | | 1962 | | 1963 | | 1964 | | 1965 | |
|---|---|---|---|---|---|---|---|---|---|---|
| Compulsory Admission | 94 | 45% | 53 | 35% | 105 | 41% | 98 | 40% | 70 | 42% |
| Voluntary Admission | 119 | | 111 | | 101 | | 116 | | 128 | |
| Out-Patient, Domiciliary | 53 | 55% | 86 | 65% | 61 | 59% | 61 | 60% | 72 | 58% |
| Home and G.P. | 144 | | 157 | | 157 | | 218 | | 174 | |
| Other | 60 | | 60 | | 84 | | 39 | | 30 | |
| TOTAL | 470 | | 467 | | 508 | | 532 | | 474 | |

* Disposal at first notification in calendar year.

## APPENDIX IV

### The Case Load* of the Mental Welfare Officer

| | 1960 | 1961 | 1962 | 1963 | 1964 | 1965 |
|---|---|---|---|---|---|---|
| A. Mental Illness | | | | | | |
| Number of new patients referred | 239 | 255 | 260 | 298 | 301 | 246 |
| Number of known patients referred | 259 | 215 | 207 | 210 | 231 | 228 |
| Total patients referred | 498 | 470 | 467 | 508 | 532 | 474 |
| Second and subsequent referrals during calendar year | 89 | 85 | 122 | 85 | 125 | 98 |
| Total referrals | 587 | 555 | 589 | 593 | 657 | 572 |
| Mental Subnormality | | | | | | |
| Number of new patients referred | 38 | 26 | 29 | 32 | 60 | 34 |
| Total New Patients Referred: Mental Illness and Mental Subnormality | 277 | 281 | 289 | 330 | 361 | 280 |
| B. Total number of visits† | 7,427 | 6,752 | 7,849 | 9,992 | 9,579 | 6,182 |
| Number of officers (units time per annum) | 5.6 | 5.06‡ | 6.63‡ | 9.03‡ | 9.13‡ | 7.42‡ |
| Average number of visits per officer | 1,326 | 1,334 | 1,184 | 1,106 | 1,049 | 820 |
| C. Average number of new patients referred per officer | 49 | 56 | 44 | 36 | 40 | 38 |
| Average number of known patients referred per officer | 46 | 42 | 31 | 23 | 25 | 31 |
| Average number of referrals per officer | 112 | 114 | 93 | 69 | 79 | 82 |
| D. Average number of visits per new patient referred | 27 | 24 | 27 | 30 | 26 | 23 |
| xAverage number of visits per total referrals | 12 | 11 | 13 | 16 | 13 | 10 |

*Excludes cases resident outside Salford (14 in 1965)

†Includes office interviews, visits to hospitals, etc.

‡Excludes trainees.

x This average is inflated because it includes visits to known subnormal patients who are not included in referrals

The figures for 1965 do not include 50 Social History Report Visits, 8 Psychiatric cases under 16 years of age and 16 Subnormal patients who had a psychiatric episode.

## APPENDIX V

New Notifications of Mentally Subnormal Persons, 1965. By Sex, Grade and Age

| GRADE* | MALES | | | | | | | | | FEMALES | | | | | | | | | Total Males and Females |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AGE | | | | | | | | Total | AGE | | | | | | | | Total | |
| | 0 – 4 | 5 – 9 | 10 – 14 | 15 – 19 | 20 – 29 | 30 – 39 | 40 – 49 | 50 + | | 0 – 4 | 5 – 9 | 10 – 14 | 15 – 19 | 20 – 29 | 30 – 39 | 40 – 49 | 50 + | | |
| Low | – | 1 | – | – | – | – | – | – | 1 | – | – | – | – | – | – | – | – | – | 1 |
| Medium | 5 | 1 | – | 3 | – | – | – | – | 9 | 2 | – | – | – | 1 | 1 | – | – | 4 | 13 |
| High | – | – | – | 7 | – | – | – | – | 7 | – | – | – | 1 | 2 | – | 1 | 1 | 5 | 12 |
| Undetermined | 3 | 1 | – | – | – | – | – | – | 4 | 3 | 1 | – | – | – | – | – | – | 4 | 8 |
| TOTALS | 8 | 3 | – | 10 | – | – | – | – | 21 | 5 | 1 | – | 1 | 3 | 1 | 1 | 1 | 13 | 34 |

## APPENDIX VI

New Notifications of Mentally Subnormal Persons, 1965. By Age and Source of Referral

| Source of Referral | AGE | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | 0 – 4 | 5 – 9 | 10 – 14 | 15 – 19 | 20 – 29 | 30 – 39 | 40 – 49 | 50 + | |
| Maternity and Child Welfare | 11 | – | – | – | – | – | – | – | 11 |
| Director of Education | – | 2 | – | 1 | – | – | – | – | 3 |
| Hospital Services | 1 | – | – | 3 | 1 | – | – | – | 5 |
| Immigration | 1 | 2 | – | 1 | 2 | 1 | – | 1 | 8 |
| Others | – | – | – | 6 | – | – | 1 | – | 7 |
| TOTAL | 13 | 4 | – | 11 | 3 | 1 | 1 | 1 | 34 |

## APPENDIX VII

New Notifications of All Mentally Subnormal Persons 1959 – 1965
Age Groups : 0 – 4 years and 15 – 19 years

| Age / Year | 0 – 4 years | | 15 – 19 years | | Percentage both Groups | Total Notifications at all ages |
|---|---|---|---|---|---|---|
| | Number | Percentage of total Notifications | Number | Percentage of total Notifications | | |
| 1959 | 13 | 32% | 12 | 29% | 61% | 41 |
| 1960 | 7 | 18% | 19 | 50% | 68% | 38 |
| 1961 | 11 | 42% | 3 | 12% | 54% | 26 |
| 1962 | 17 | 59% | 4 | 14% | 73% | 29 |
| 1963 | 21 | 68% | 3 | 10% | 78% | 31 |
| 1964 | 24 | 39% | 16 | 27% | 66% | 62 |
| 1965 | 13 | 38% | 11 | 32% | 70% | 34 |

## APPENDIX VIIIA

New Notifications during 1963, 1964 and 1965 of Mentally Subnormal Persons under Five years of Age

| Age | 0 – | 1 – | 2 – | 3 – | 4 – | Total 0 – 4 |
|---|---|---|---|---|---|---|
| 1963 | 1 | 1 | 9 | 8 | 2 | 21 |
| 1964 | 3 | 6 | 9 | 4 | 2 | 24 |
| 1965 | 2 | 3 | 5 | 3 | – | 13 |

## APPENDIX VIIIB

New Notifications to Mental Health Department during 1965, Aged 0 – 4 years: Age of original Notification to Health Department (M. & C.H.).

| 0 – | 1 – | 2 – | 3 – | 4 – | Total |
|---|---|---|---|---|---|
| 9 | 1 | 2 | 1 | – | 13 |

5 cases were referred during the first month of life.

## APPENDIX IX

Alterations in Status of Mentally Subnormal Persons on the Salford Register during 1965 by Age and Sex

| | MALES | | | | | | | | | FEMALES | | | | | | | | | Total Males and Females |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AGE | | | | | | | | Total | AGE | | | | | | | | Total | |
| | 0 – 4 | 5 – 9 | 10 – 14 | 15 – 19 | 20 – 29 | 30 – 39 | 40 – 49 | 50 + | | 0 – 4 | 5 – 9 | 10 – 14 | 15 – 19 | 20 – 29 | 30 – 39 | 40 – 49 | 50 + | | |
| Discharged from care 1965 | – | 1 | – | – | 11 | 4 | 3 | 1 | 20 | – | – | – | – | 5 | 2 | – | 2 | 9 | 29 |
| Migration 1965 | 1 | – | – | 1 | – | – | 1 | 1 | 4 | 1 | 1 | – | – | 2 | 1 | 1 | 4 | 10 | 14 |
| Additions to previous years | – | – | – | – | 1 | – | 3 | – | 4 | – | 1 | – | – | 2 | 3 | 1 | 2 | 9 | 13 |
| Deaths 1965 | 1 | – | – | – | 1 | – | – | – | 2 | – | – | – | – | – | – | – | – | – | 2 |
| Additions to previous years | – | – | – | – | 1 | 1 | 1 | 5 | 8 | – | – | – | – | – | – | – | 4 | 4 | 12 |
| Not Located 1965 | – | – | – | – | – | 1 | 1 | 4 | 6 | – | – | – | – | 1 | 2 | – | 1 | 4 | 10 |
| | | | | | | | | | 44 | | | | | | | | | 36 | 80 |
| Discharged from Hospital 1965 | – | – | – | 1 | – | – | 1 | 2 | 4 | – | – | – | – | 1 | – | – | 2 | 3 | 7 |
| Additions to previous years | – | – | – | – | – | – | 4 | 2 | 6 | – | – | – | – | 1 | 3 | 1 | 2 | 7 | 13 |
| Admitted to Hospital 1965 | 1 | – | – | 3 | 1 | 1 | – | – | 6 | – | 1 | – | 1 | – | 1 | – | – | 3 | 9 |

Admitted to Hospital Short-Term Care during 1965 – 15 persons, for 17 short periods, 2 converting to full admission and included above.

## APPENDIX X

Adult Day Centres – Register, Admissions and Discharges for 1963–65.

| | MEN | | | WOMEN | | | ALL | | |
|---|---|---|---|---|---|---|---|---|---|
| | Mentally Subnormal | Mentally Ill | Total | Mentally Subnormal | Mentally Ill | Total | Mentally Subnormal | Mentally Ill | Total |
| Number on registers 31.12.1963 | 44 | 21 | 65 | 45 | 25 | 70 | 89 | 46 | 135 |
| Number on registers 31.12.1964 | 57 | 15 | 72 | 34 | 43 | 77 | 91 | 58 | 149 |
| Number on registers 31.12.1965 | 49 | 27 | 76 | 31 | 65 | 96 | 80 | 92 | 172 |
| Average daily attendance 1963 | | | | | | | | | 109 |
| Average daily attandance 1964 | | | | | | | | | 113 |
| Average daily attendance 1965 | | | | | | | | | 120 |
| Number of admissions 1963 | 30 | 27 | 57 | 12 | 22 | 34 | 42 | 49 | 91 |
| Number of admissions 1964 | 35 | 22 | 57 | 32 | 69 | 101 | 67 | 91 | 158 |
| Number of admissions 1965 | 23 | 44 | 67 | 21 | 103 | 124 | 44 | 147 | 191 |
| Discharges 1963 | 36 | 19 | 55 | 15 | 21 | 36 | 51 | 40 | 91 |
| Discharges 1964 | 22 | 28 | 50 | 40 | 54 | 94 | 62 | 82 | 144 |
| Discharges 1965 | 31 | 32 | 63 | 24 | 81 | 105 | 55 | 113 | 168 |
| Discharges 1965 | | | | | | | | | |
| Work | 9 | 11 | 20 | 7 | 3 | 10 | 16 | 14 | 30 |
| Household Duties | – | – | – | 2 | 3 | 5 | 2 | 3 | 5 |
| Migrated | 3 | – | 3 | – | 3 | 3 | 3 | 3 | 6 |
| Transferred to other centres | 5 | 5 | 10 | 2 | – | 2 | 7 | 5 | 12 |
| Defaulted | 10 | 9 | 19 | 7 | 16 | 23 | 17 | 25 | 42 |
| Rehabilitation Unit | 1 | 1 | 2 | – | – | – | 1 | 1 | 2 |
| Died | – | 1 | 1 | – | 3 | 3 | – | 4 | 4 |
| Sick | – | – | – | – | 1 | 1 | – | 1 | 1 |
| Hospital | 3 | 4 | 7 | 6 | 52 | 58 | 9 | 56 | 65 |
| Excluded | – | 1 | 1 | – | – | – | – | 1 | 1 |

N.B. Discharges to hospital in 1965 includes many who attended Cleveland Day Centre whilst being in-patients in Hope Hospital

## APPENDIX XI

Trainees entering employment from Adult Centres in 1965

| | Age | I.Q. | Period Unemployed | Centre Attendance | Centre Attended | Type of Employment | Result |
|---|---|---|---|---|---|---|---|
| Mentally Ill Males | 65 | | Several years | Several years | Broad Street | Porter | For 2 weeks only |
| | 61 | | Many years hospitalised | 7 months | Acton Square | Kitchen Porter | Stable |
| | 24 | | Several months | 6 weeks | Acton Square | Labourer-Scrap Metal Firm | Stable |
| | 57 | | Many years hospitalised | 6 months | Acton Square | Hotel Night Porter | For 3 days only then returned to centre |
| | 23 | | Never worked before | 2 months | Acton Square | Hoistman | Worked 1 month then returned to centre |
| | 37 | | Short period only | 2 days | Acton Square | Labourer - Building | Stable |
| | 44 | | Many years hospitalised | 1 week | Acton Square | Cleaner at Garage | 2 months, returned to centre |
| | 22 | | Short period only | 2 days | Acton Square | Machine Binder | Stable |
| | 40 | | Short period only | 6 weeks | Acton Square | Labourer - Building Site | Stable |
| | 41 | | Sporadic jobs | 5 months | Acton Square | Temporary Postman | Returned to centre |
| | 34 | | Sporadic jobs | 3 weeks | Acton Square | Warehouse Labourer | Stable |
| Females | 25 | | Long periods | 4 months | Out Workers | Cleaner | 1 week only then returned to centre |
| | 45 | | Short period only | 1 month | Out Workers | Cleaner | Stable |
| | 51 | | Sporadic jobs | 4 months | Crescent | Cleaner | 7 weeks, then returned to centre |
| | 35 | | Several years | Several years | Cleveland House | Cleaner | Stable |

## APPENDIX XI (continued)

Trainees entering employment from Adult Centres in 1965

| | Age | I.Q. | Period Unemployed | Centre Attendance | Centre Attended | Type of Employment | Result |
|---|---|---|---|---|---|---|---|
| Subnormal Males | 44 | | Many years hospitalised | 2½ months | Broad Street | Labourer | For 3 months |
| | 52 | | Many years hospitalised | 8 months | Broad Street | Labourer - Timber Firm | For 2 weeks, then returned to centre |
| | 52 | | Several years | Several years | Broad Street | Labourer | For 4 months, returned to centre |
| | 44 | | Many years hospitalised | 3½ months | Broad Street | Labourer | One month, then returned to centre |
| | 28 | | Never worked before | Many years | Broad Street | Car Washing | Stable |
| | 43 | | Many years hospitalised | 16 months | Broad Street | Labourer | 2 weeks, then returned to centre |
| | 23 | | Sporadic jobs | 3 months | Acton Square | Hoistman | Stable |
| | 19 | | Never worked before | 3 months | Acton Square | Temporary Postman | Returned to centre |
| | 55 | | Many years hospitalised | 6 months | Out Workers | Kitchen Hand | Stable |
| Females | 28 | | Never worked before | Many years | Crescent | Kitchen Maid | Stable |
| | 18 | | Sporadic jobs | Short period only | Out Workers | Part-time Cleaner | Returned to centre |
| | 44 | | Never worked before | 6 months | Out Workers | Cleaner | Stable |
| | 50 | | Sporadic jobs | Many years off and on | Out Workers | Kitchen Maid | Stable |
| | 43 | | Sporadic jobs | Many years off and on | Out Workers | Kitchen Maid | Stable |
| | 35 | | Sporadic jobs | Many years off and on | Out Workers | Kitchen Maid | Stable |

## APPENDIX XII

HOSTELS: Residence, Admissions, Discharges 1963 – 1965

| | MEN | | | WOMEN | | | ALL | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1963 | 1964 | 1965 | 1963 | 1964 | 1965 | 1963 | 1964 | 1965 |
| ADMISSIONS | | | | | | | | | |
| One admission only | 19 | 27 | 26 | 20 | 27 | 25 | 39 | 54 | 51 |
| More than one admission | 1 | 1 | 3 | 5 | 6 | 5 | 6 | 7 | 8 |
| Reasons for Admission | | | | | | | | | |
| No Home | 8 | 3 | 11 | 18 | 7 | 11 | 26 | 10 | 22 |
| Lack of economic resources | 2 | 3 | 2 | 2 | – | 5 | 4 | 3 | 7 |
| Half-Way House from Hospital | 10 | 15 | 6 | 4 | 10 | 2 | 14 | 25 | 8 |
| Need for Protected Environment | 6 | 2 | 2 | 7 | 4 | 6 | 13 | 6 | 8 |
| Short-Term Care | 6 | 6 | 9 | 4 | 8 | 4 | 10 | 14 | 13 |
| Domestic Tension | 3 | – | 3 | 6 | 12 | 1 | 9 | 12 | 4 |
| Leave from Hospital | – | 1 | – | 1 | 6 | 4 | 1 | 7 | 4 |
| En Route to Hospital | – | – | – | – | – | 3 | – | – | 3 |
| Diagnosis | | | | | | | | | |
| Psychosis | 12 | 12 | 22 | 7 | 15 | 15 | 19 | 27 | 37 |
| High Grade Subnormality | 7 | 3 | 3 | 9 | 15 | 10 | 16 | 18 | 13 |
| Medium Grade Subnormality | 8 | 14 | 8 | 14 | 10 | 7 | 22 | 24 | 15 |
| Neurosis | 2 | – | – | 7 | – | 1 | 9 | – | 1 |
| Psychopathy | 5 | 1 | – | 2 | 1 | 3 | 7 | 2 | 3 |
| Not Determined | 1 | – | – | 3 | 6 | – | 4 | 6 | – |
| Age Groups | | | | | | | | | |
| 15 – | 13 | 8 | 7 | 14 | 13 | 5 | 27 | 21 | 12 |
| 25 – | 5 | 2 | 2 | 3 | 9 | 8 | 8 | 11 | 10 |
| 35 – | 10 | 11 | 11 | 12 | 14 | 6 | 22 | 25 | 17 |
| 45 – | 4 | 8 | 8 | 8 | 8 | 7 | 12 | 16 | 15 |
| 55 – | 3 | 7 | 4 | 5 | 6 | 8 | 8 | 13 | 12 |
| 65 + | – | – | 1 | – | – | 2 | – | – | 3 |
| Number Obtained Employment after Admission | 5 | 10 | 8 | 8 | 13 | 13 | 13 | 23 | 21 |

HOSTELS: Residence, Admissions, Discharges 1963 – 1965

| | MEN | | | WOMEN | | | ALL | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1963 | 1964 | 1965 | 1963 | 1964 | 1965 | 1963 | 1964 | 1965 |
| DISCHARGES | | | | | | | | | |
| One discharge only | 25 | 18 | 26 | 21 | 24 | 23 | 46 | 42 | 49 |
| More than one discharge | 1 | 1 | 3 | 6 | 11 | 4 | 7 | 12 | 7 |
| Duration of Stay | | | | | | | | | |
| <1 month | 9 | 10 | 16 | 19 | 28 | 12 | 28 | 38 | 28 |
| 1 month – | 8 | 6 | 6 | 6 | 8 | 8 | 14 | 14 | 14 |
| 3 months – | 2 | 2 | 4 | 3 | 5 | 6 | 5 | 7 | 10 |
| 6 months – | 3 | 1 | 2 | 2 | – | 3 | 5 | 1 | 5 |
| 9 months – | 1 | 1 | 1 | – | 1 | 1 | 1 | 2 | 2 |
| 12 months – | 5 | 1 | 4 | 4 | 7 | 2 | 9 | 8 | 6 |
| Outcome | | | | | | | | | |
| Satisfactory | 16 | 16 | 27 | 27 | 37 | 22 | 43 | 53 | 49 |
| Left by agreement | 1 | – | 5 | 2 | 4 | 5 | 3 | 4 | 10 |
| Placement (Home, Lodging, Foster-Care) | 9 | 9 | 14 | 16 | 22 | 7 | 25 | 31 | 21 |
| Return home after short-term care | 6 | 6 | 8 | 5 | 7 | 4 | 11 | 13 | 12 |
| Following leave from hospital | – | 1 | – | 2 | 4 | 3 | 2 | 5 | 3 |
| En route to hospital | – | – | – | 2 | – | 3 | 2 | – | 3 |
| Unsatisfactory | 12 | 5 | 6 | 7 | 12 | 10 | 19 | 17 | 16 |
| Deterioration & admission to hospital | 6 | 2 | 3 | 4 | 3 | 9 | 10 | 5 | 12 |
| Delinquency and Court action | – | – | – | – | – | – | – | – | – |
| Left without consultation | 5 | 3 | 3 | 3 | 8 | 1 | 8 | 11 | 4 |
| Expelled | 1 | – | – | – | 1 | – | 1 | 1 | – |

## APPENDIX XIIIA

Patients in Residence in Hostels, by Age and Sex

| MEN | 15 – | 25 – | 35 – | 45 + | ALL |
|---|---|---|---|---|---|
| At 31.12.64 | 2 | – | 6 | 10 | 18 |
| At 31.12.65 | – | – | 7 | 11 | 18 |
| WOMEN | | | | | |
| At 31.12.64 | 2 | 3 | 4 | 7 | 16 |
| At 31.12.65 | 1 | 3 | 8 | 8 | 20 |
| TOTAL | | | | | |
| At 31.12.64 | 4 | 3 | 10 | 17 | 34 |
| At 31.12.65 | 1 | 3 | 15 | 19 | 38 |

## APPENDIX XIIIB

Patients in Residence in Hostels, by Diagnosis and Sex

| MEN | Psychosis | High Grade Sub-Normal | Medium Grade Sub-Normal | Neurosis | Psychopath | Not Determined | Total |
|---|---|---|---|---|---|---|---|
| At 31.12.64 | 7 | 2 | 8 | – | 1 | – | 18 |
| At 31.12.65 | 12 | – | 5 | – | 1 | – | 18 |
| WOMEN | | | | | | | |
| At 31.12.64 | 6 | 3 | 6 | 1 | – | – | 16 |
| At 31.12.65 | 5 | 5 | 9 | 1 | – | – | 20 |
| ALL | | | | | | | |
| At 31.12.64 | 13 | 5 | 14 | 1 | 1 | – | 34 |
| At 31.12.65 | 17 | 5 | 14 | 1 | 1 | – | 38 |

## APPENDIX XIIIC

Patients in Residence in Hostels, by Duration of Stay

| | Less than 1 month | 1 month | 3 months | 6 months | 9 months | 12 months | Median |
|---|---|---|---|---|---|---|---|
| At 31.12.64 | 4 | 11 | 5 | 4 | 1 | 9 | 3 months |
| At 31.12.65 | 8 | 2 | 7 | 4 | 2 | 15 | 6 months |



## APPENDIX XIIID

Patients in Residence in Hostels, by Employment

| | MEN | | WOMEN | | ALL | |
|---|---|---|---|---|---|---|
| | Working | Unemployed | Working | Unemployed | Working | Unemployed |
| At 31.12.64 | 5 | 13 | 4 | 12 | 9 | 25 |
| At 31.12.65 | 3 | 15 | 9 | 11 | 12 | 26 |

## APPENDIX XIV

Mental Health Department – Staff

| | 31.12.1964 | Resigned 1965 | Appointed 1965 | 31.12.1965 |
|---|---|---|---|---|
| MEDICAL | | | | |
| Senior Assistant Medical Officer (Part-time) | 1 | 1 | – | – |
| Assistant Medical Officers (Part-time) | 2 | 1 | – | 1 |
| CONSULTANTS | | | | |
| Psychiatrist (one session per week) | 1 | – | – | 1 |
| Paediatrician (one session per week) | 1 | – | – | 1 |
| EDUCATIONAL | | | | |
| Educational Organiser | – | – | 1 | 1 |
| Psychologists (sessional work) | 4 | 1 | – | 3 |
| Remedial Teachers | 2 | 2 | – | – |
| SOCIAL WORKERS | | | | |
| Chief Mental Welfare Officer | 1 | – | – | 1 |
| Deputy Chief Mental Welfare Officer | – | – | 1 | 1 |
| Psychiatric Social Worker | 1 | 1 | 1 | 1 (part time) |
| Mental Welfare Officers | 7 (inc. 1 part-time) | 4 (inc. 1 part-time) | 3 (inc. 1 part-time) | 6 (inc. 1 part-time) |
| ADMINISTRATION | | | | |
| Chief Clerk | 1 | 1 | – | – |
| Administrative Assistant | 1 | – | – | 1 |
| Clerks | 1 | 1 | 2 | 2 |
| Shorthand Typists | 2 | 1 | 1 | 2 |
| TRAINING CENTRES | | | | |
| Supervisors | 4 | – | – | 4 |
| Assistant Supervisors | 20 (inc. 2 temp) | 3 | 3 | 20 (inc. 1 temp) |
| Centre Assistants | 1 | – | 2 | 3 |
| Physiotherapist (part-time) | 1 | 1 | – | – |
| RESIDENTIAL HOSTELS | | | | |
| Wardens | 2 | – | – | 2 |
| Assistant Wardens | 4 | 3 | – | 1 |

# IMMUNISATION SECTION

During the year 2,698 children in the age group 0 – 15 years completed a course of immunisation against diphtheria, whooping cough and tetanus.

Below are the statistics relating to the year's work :–

| | 0 – 5 years | 5 – 15 years | 0 – 15 years |
|---|---|---|---|
| Number immunised during the year ended 31st December, 1965 | 2,579 | 119 | 2,698 |
| Total completed immunisation at 31st December, 1965 | 9,906 | 20,300 | 30,206 |
| Population figures, 1965 | 14,200 | 21,900 | 36,100 |
| Percentage immunised at 31st December, 1965 | 69.7% | 92.6% | 83.6% |

The children were immunised as follows :–

| | |
|---|---|
| At child welfare centres by health visitors and clinic nurses | 1,711 |
| By public health nursing staff in the homes of the children | 664 |
| By nursing staff at schools | 119 |
| By general practitioners | 201 |
| At Greenbank Nursery | 3 |
| | 2,698 |

Of the 2,698 children completing immunisation 2,682 received diphtheria, pertussis and tetanus (triple antigen) injections, and 16 received diphtheria and tetanus injections. 812 booster doses of diphtheria and tetanus were given to school children during 1965, and 1,317 children aged 0 – 5 years were given a booster dose of triple antigen twelve months after the completion of primary immunisation.

## WHOOPING COUGH IMMUNISATION

2,579 children received whooping cough immunisation during the year; all these children were given triple antigen injections.

## POLIOMYELITIS VACCINATION

The following figures show the number of children who have completed a course of oral poliomyelitis vaccination during the year.

| | 3rd dose | 4th dose |
|---|---|---|
| Children 0 – 5 year (1961 – 1965) | 3,088 | 2,120 |
| Children 5 – 15 years (1951 – 1960) | 1,187 | 18,499 |
| Young people (age group 1933 – 1950) | 890 | 1,922 |
| Older people up to 40 years of age | 1,400 | 1,945 |
| Older adults over 40 years of age | | 1,649 |

During August and September cases of poliomyelitis occurred in Blackburn and other neighbouring authorities, and because of the surprising number of people who travel to work in Salford from Blackburn and surrounding areas it was thought wise to offer a booster dose of oral poliomyelitis vaccine to everyone in the City.

It was decided to offer poliomyelitis vaccination every afternoon and two evenings per week at a clinic in the basement of the Health Department; this clinic had been set up to offer Health Check-up and Mass Radiography. In addition, all the schools in Salford were visited and boosters of poliomyelitis vaccination given. The above figures give an indication of the success of the campaign. The main success of the campaign of course was that no cases of poliomyelitis were reported in Salford.

The figures below show the total number of poliomyelitis vaccinations given at 31st December, 1965 :–

| | Completed Salk & Oral Vaccination | | Booster Salk & Oral Vaccination | |
|---|---|---|---|---|
| 0 – 5 years (1961 – 1965) | 9,644 | 68% | 2,284 | |
| 5 – 15 years (1951 – 1960) | 20,862 | 93% | 28,000 | 97% |
| 0 – 15 years (1951 – 1965) | 30,506 | 83% | 30,284 | 82% |
| Young Persons (1933 – 1950) | 24,844 | 55% | 4,571 | 10% |
| Older People to 40 years of age | 8,431 | 15% | | |

## B.C.G. VACCINATION

The figures below are the number of Mantoux tests and B.C.G. Vaccinations given to 13 year old children and older children who had missed previous vaccination sessions, also students attending further education establishments.

| | Consents | Positive | Negative | D.N.A. | B.C.G. Vaccination |
|---|---|---|---|---|---|
| Boys | 570 | 50 | 400 | 120 | 400 |
| Girls | 641 | 47 | 478 | 116 | 478 |
| Total | 1,211 | 97 | 878 | 236 | 878 |
| Students | 1 | 1 | 1 | – | 1 |

Mantoux investigation at Stowell Memorial School on the 23rd November, 1965 :–

6 Positive and 27 negative.

## SMALLPOX VACCINATION

Below are statistics relating to smallpox vaccination given to children during the year.

| Age at date of vaccination in the year | Under 1 year | 1 year | 2 – 4 years | 5 – 14 years | 15 years and over | Total |
|---|---|---|---|---|---|---|
| Primary vaccinations | 92 | 504 | 173 | 23 | 9 | 801 |
| Re-vaccinations | – | – | 6 | 21 | 97 | 124 |

# INFECTIOUS DISEASES

The following table shows the number of infectious diseases notified during the year :–

| Disease | All ages | Under 1 year | 1 – 5 years | 5 – 15 years | 15 – 25 years | 25 – 45 years | 45 – 65 years | 65 years and over |
|---|---|---|---|---|---|---|---|---|
| Scarlet Fever | 55 | 1 | 23 | 29 | 2 | – | – | – |
| Whooping Cough | 22 | 6 | 12 | 3 | 1 | – | – | – |
| Measles | 824 | 43 | 519 | 249 | 13 | – | – | – |
| Dysentery | 48 | 10 | 19 | 9 | 6 | 4 | – | – |
| Pneumonia | 5 | – | – | 2 | – | 3 | – | – |
| Erysipelas | 2 | – | – | – | – | – | – | 2 |
| Food Poisoning | 10 | 4 | 3 | 2 | – | 1 | – | – |
| Ophthalmia Neonatorum | 1 | 1 | – | – | – | – | – | – |
| Puerperal Pyrexia | 32 | – | – | – | 29 | 3 | – | – |
| Rheumatism | 3 | – | – | 3 | – | – | – | – |
| Tuberculosis (Respiratory) | 42 | 1 | – | 2 | 3 | 18 | 15 | 3 |
| Tuberculosis (Other Forms) | 2 | – | – | – | – | – | 2 | – |
| | 1,046 | 66 | 576 | 299 | 54 | 29 | 17 | 5 |

# AMBULANCE SERVICE

The following tables give particulars of patients carried and mileage run during 1965, as compared with the previous year :–

| Class of Patient | 1965 | | 1964 | |
|---|---|---|---|---|
| | Patients | Miles | Patients | Miles |
| House Conveyance | 62,041 | 159,089 | 67,623 | 166,602 |
| Inter-Hospital | 2,508 | 13,958 | 2,975 | 12,777 |
| Maternity | 1,593 | 10,195 | 1,574 | 10,060 |
| Mental Health Hospitals | 7,609 | 12,336 | 5,863 | 12,595 |
| Chargeable to other Authorities | 208 | 2,210 | 298 | 3,102 |
| Emergency | 4,938 | 20,532 | 4,772 | 19,946 |
| Infectious | 12 | 87 | 23 | 198 |
| Miscellaneous | – | 3,519 | – | 3,287 |
| TOTAL | 78,909 | 221,926 | 83,128 | 228,567 |
| Class of Vehicle | | | | |
| Ambulance | 71,010 | 187,748 | 74,151 | 190,452 |
| Car | 7,899 | 34,178 | 8,977 | 38,115 |
| TOTAL | 78,909 | 221,926 | 83,128 | 228,567 |

Other than Section 27 Patients – for Recharge

| Class of Patient | 1965 | | 1964 | |
|---|---|---|---|---|
| | Patients | Miles | Patients | Miles |
| Midwives | *1,427** | 8,974 | 2,137 | 9,642 |
| Gas/Air | *468** | 1,575 | 451 | 1,557 |
| Premcots | *93** | 439 | 94 | 408 |
| Mental Health (Centre) | 15,791 | 16,065 | 10,349 | 10,631 |
| Handicapped Persons | 2,422 | 1,718 | 2,482 | 1,863 |
| Spastics | 4,624 | 5,936 | 4,119 | 5,282 |
| TOTAL | 22,837 | 34,707 | 19,632 | 29,383 |

* *Visits*

## TOTAL PATIENTS CARRIED AND MILEAGE RUN

| | *1965* | *1964* |
|---|---|---|
| Patients carried | 101,746 | 102,760 |
| Mileage run | 256,633 | 257,950 |

During the year, the ambulances carried 93,722 patients and travelled 213,119 miles, and the sitting-case cars carried 8,024 patients and travelled 43,514 miles.

At the end of the year there were in operation 11 ambulances, 4 sitting-case ambulances, and 2 sitting-case cars.

The staff consisted of an Ambulance Officer, a Deputy Ambulance Officer, a Station Officer, three Shift Leaders, one female Radio-telephone Operator, one General Duties man, and 42 Driver/Attendants.

The Variety Club of Great Britain have kindly donated a 20-seater coach for the transport of handicapped children, and this is being operated by the Ambulance Service.

During the year the 'Minuteman' Resuscitator was introduced.

Eleven vehicles are now painted in white, a colour which will ultimately cover the whole fleet.

# HEALTH EDUCATION

Health Education with its twin aims of preventing illness and promoting good health once again took practical form in the organisation of the annual Health Check-up. For the first time the campaign was held in conjunction with the X-ray test conducted by the Manchester Regional Hospital Board's Mobile Unit. Both campaigns were held in the basement of the new Health Department.

Initially both campaigns suffered from teething troubles but these were soon ironed out. The experience gained will undoubtedly help very much in the future.

Some 6,253 people attended for X-ray, an increase of 36 over the previous year.

The tests for the detection of diabetes, anaemia, blood pressure, etc. carried out by the nursing staff, were attended by 3,105 people, a decrease of 346 over the previous year.

One of the most disturbing facts to be seen from the results of the tests was the high percentage of drivers who have defective vision – 62%. It is little wonder that the road casualty rates are as high as they are when such a large proportion of drivers are in need of a visit to their optician.

Other interesting facts found were that 31% of people tested were over-weight, 33% had a high blood pressure, 9% had a low haemoglobin and finally 6% had sugar in their blood.

In future years it is hoped to extend the tests to make the Check-up a more comprehensive guide to health.

## ANTI-ADDICTION CLINIC

The anti-addiction clinic has continued weekly throughout the year; it has catered mainly for people who want to stop smoking but attenders with weight problems have also been helped.

### Anti-Smoking

300 people attended for the first time during 1965 (an increase of 10%), giving a total of 911 attendances at the 46 sessions. Numbers have fluctuated throughout the year: following the budget in April, 56 people attended but towards the end of the year attendances dropped considerably. The average attendance was 18. Of the 300, however, 154 people attended once only and the small number of 33 attended more than three times. Only 4 people who attended in 1964 returned during 1965. Thus it becomes increasingly difficult to gain results and to glean information.

It is, however, known that :–

62 attenders stopped smoking completely

30 attenders cut down by 50% or more

30 attenders cut down

The remaining 182 attenders – no information or no success.

A questionnaire is completed at the first attendance. The following details were obtained in reply to the question – "Why do you want to give up smoking ?"

For reasons of health : 33%

For reasons of health + finance : 28%

For reasons of health + other reasons : 20%

Thus showing that many people do realise the dangers of smoking.

## 5 – DAY PLAN TO STOP SMOKING

In addition to the usual weekly session a five day plan was held in January, 1965.

92 different people attended the course.
41 attended 5 nights
21 attended 4 nights
11 attended 3 nights
12 attended 2 nights
7 attended 1 night

65 forms were completed at the end of the course and these showed a 90% success.

## HOME SAFETY

### HOME ACCIDENTS TREATED AT SALFORD ROYAL HOSPITAL DURING 1965

| | Male | | Female | | Total | |
|---|---|---|---|---|---|---|
| | Fatal | Non-fatal | Fatal | Non-fatal | Fatal | Non-fatal |
| Burns and Scalds | 1 | 179 | 2 | 204 | 3 | 383 |
| Falls | 3 | 682 | 16 | 840 | 19 | 1,522 |
| Lacerations | – | 405 | – | 286 | – | 691 |
| Poisoning | – | 95 | – | 88 | – | 183 |
| Overdose | 3 | 66 | 4 | 158 | 7 | 224 |
| Dog and Cat bites | – | 58 | – | 50 | – | 108 |
| Assault | – | 14 | – | 36 | – | 50 |
| Gas Poisoning | – | 10 | – | 5 | – | 15 |
| Swallowing foreign bodies | – | 115 | – | 96 | – | 211 |
| Miscellaneous | 3 | 1,907 | – | 1,579 | 3 | 3,486 |
| TOTALS | 10 (10) | 3,531 (3,917) | 22 (22) | 3,342 (3,655) | 32 (32) | 6,873 (7,572) |

1964 Figures in brackets

It is pleasing to note the decrease in the number of home accidents during 1965, but the above figures show how great the need is for increased public awareness of dangers in the home.

During the year the Home Safety Committee produced a new edition of the handbook. A one-day Home Safety Exhibition was held in the Health Department on 2nd June, 1965.

# SALFORD HOUSE

Salford House provides separate cubicle accommodation for 285 men. During 1965 the average number of residents was 278 per night and the charges were maintained at 35/- a week (or 5/6 per night).

The number of permanent residents remains high, the figure being approximately 75%. Of this number, 60% are old age pensioners or disabled men, the remaining 15% being in regular work in the district. The new admissions came mainly from areas of heavy unemployment, such as Glasgow, the North East, Belfast and Eire, and were mostly unskilled labourers. Many of these men found work in the district and became regulars at Salford House. Casuals staying only for one or two nights, number less than 5% of the total.

The various services provided by the local authority, and in particular the Health Department, are used to full advantage by the permanent residents and are greatly appreciated. The health visitor calls regularly and the men discuss their health problems and accept advice and guidance. The chiropody service which serves Salford House monthly, is also highly esteemed.

The National Assistance Board, working in liaison with the management of Salford House, provided many needy cases with additional help in the form of allowances for clothing and boots.

The Christmas dinner was again a great success and 140 pensioners and disabled men enjoyed an excellent meal. The pleasure of the occasion was enhanced by the attendance of the Chairman of the Health Committee. The City of Salford Companionship Circle for the Elderly provided gifts for all old age pensioners and the Almoner and Nursing Staff of the Manchester Dental Hospital made gifts to 50 residents. A hundred Christmas parcels were also received from the Wood Street Mission. Booths Charities made their annual gift of boots and shirts to 20 locally-born old age pensioners.

The Hostel was visited by several parties of students from hospitals and welfare organisations who wished to see how a municipal hostel is run.

The Social Club continues to be a popular feature of the Hostel and helps the men to feel that Salford House is not just another lodging house but is their home. The snack bar provides a good variety of light meals at low prices and is a great boon to men who do not always feel like cooking for themselves. Recreation is provided in the form of billiards, darts, etc. and a T.V. Lounge which draws a full house every night. Snooker and darts teams from local clubs are also entertained and a social evening is held once a month. These activities all help the men to get along together and make them feel that they are part of the small community which is Salford House.